Design Guide

MC0307

Design Guide

The design of community hospitals

NHS Estates
An Executive Agency of the Department of Health

Design Guide

The design of community hospitals

LONDON: HMSO

NHS Estates
An Executive Agency of the Department of Health

© Crown copyright 1991
First published 1991

ISBN 0 11 321402 2

About this publication

This guidance seeks to explain and promote the community hospital concept as an essential and integral part of both today's and tomorrow's health care system. It does not promote specific design solutions because there is no one "blueprint" for a community hospital. Instead it provides a framework of guiding principles for community hospital planning and design which can be interpreted and acted upon to produce design solutions to suit local circumstances and requirements. These principles also provide a basis for evaluating developing designs for new community hospitals and for post occupancy evaluations of completed hospitals.

Technological developments, organisational change, needs-based service assessments and increasing cost consciousness will lead to greater questioning of what services really need to be provided in acute hospital environments. There will be increasing recognition of the scope for "unbundling" of some acute services into community and primary care settings.

As these changes gather pace, community hospitals will have an essential role to play as a versatile, flexible, and affordable response to the need for locally appropriate health care and health promotion services in non-clinical, consumer oriented settings which are close to people's homes.

Contents

Preface

Acknowledgements

List of photographs

1.0 **Introduction** *page* 9
1.1 Aims of document
1.2 Audience
1.3 Structure of guidance
1.4 Exclusions

2.0 **Concept and philosophy** *page* 11
2.1 What is a community hospital?
2.2 What is the future role of community hospitals?
2.3 When is community hospital development appropriate?
2.3.1 Integration and decentralisation
2.3.2 Rationalisation
2.3.3 Expansion of services for elderly people and local population
2.3.4 Flexible response to change
2.4 What are the benefits of community hospitals?
2.4.1 Benefits for patients
2.4.2 Benefits for staff
2.4.3 Benefits to DHAs, Units and Trusts
2.5 What are possible concerns about community hospitals?
2.5.1 Concerns for staff
2.5.2 Concerns for DHAs, Units and Trusts

3.0 **Service planning issues and options** *page* 20
3.1 Range and mix of services
3.2 Key service planning issues
3.3 Viability and scope of particular services
3.4 Relationship with community health clinics and primary care services
3.5 Interagency co-operation

4.0 **Assessment of demand and "sizing" of services** *page* 24

5.0 **Quality of environment** *page* 25
5.1 Philosophy of care
5.2 Ethos of environment
5.3 Total quality management

6.0 **Location and site selection** *page* 26
6.1 Accessibility
6.2 Physical site characteristics
6.3 Relationship with primary care facilities

7.0 Whole hospital planning issues *page* 27
7.1 Scale and style
7.2 Integration with other facilities
7.3 Zoning and relationships between services
7.4 Information technology
7.5 Design of inpatient facilities
7.6 Privacy and confidentiality
7.7 Role of outdoor space
7.8 Logistics and communications strategy
7.9 Expansion strategy
7.10 Flexible and shared use of space
7.11 Interior design

8.0 **Whole hospital operational policies with implications for design and space utilisation** *page* 38

9.0 **Planning accommodation for community hospital services** *page* 39
9.1 Inpatient accommodation
9.1.1 Scope
9.1.2 Sizing
9.1.3 Other relevant guidance
9.1.4 Operational policies
9.1.5 Planning issues and options
9.1.6 Relationship with other services
9.1.7 Total quality management
9.1.8 Interior design
9.2 Day hospital services
9.2.1 Scope
9.2.2 Sizing
9.2.3 Other relevant guidance
9.2.4 Operational policies
9.2.5 Planning issues and options
9.2.6 Relationship to other services
9.2.7 Total quality management
9.2.8 Interior design
9.2.9 Multi-use of space
9.3 Physiotherapy
9.3.1 Scope
9.3.2 Sizing
9.3.3 Other relevant guidance
9.3.4 Operational policies
9.3.5 Planning issues and options
9.3.6 Relationship to other services
9.3.7 Total quality management
9.3.8 Multi-use of space
9.4 Occupational therapy
9.4.1 Scope
9.4.2 Sizing
9.4.3 Other relevant guidance
9.4.4 Operational policies
9.4.5 Planning issues and options
9.4.6 Relationship to other services
9.4.7 Interior design
9.4.8 Multi-use of space

9.5 Clinic services
9.5.1 Scope
9.5.2 Sizing
9.5.3 Other relevant guidance
9.5.4 Operational policies
9.5.5 Planning issues and options
9.5.6 Relationship to other services
9.5.7 Total quality management
9.5.8 Interior design
9.5.9 Multi-use of space
9.6 Minor casualty
9.6.1 Scope
9.6.2 Sizing
9.6.3 Other relevant guidance
9.6.4 Operational policies
9.6.5 Planning issues and options
9.6.6 Relationship to other services
9.6.7 Total quality management
9.6.8 Interior design
9.6.9 Multi-use of space
9.7 Radiodiagnostics
9.7.1 Scope
9.7.2 Sizing
9.7.3 Other relevant guidance
9.7.4 Operational policies
9.7.5 Planning issues and options
9.7.6 Relationship to other services
9.7.7 Total quality management
9.7.8 Interior design
9.7.9 Multi-use of space
9.8 Main entrance
9.8.1 Scope
9.8.2 Other relevant guidance
9.8.3 Operational policies
9.8.4 Planning issues
9.8.5 Relationship to other services
9.8.6 Total quality management and interior design
9.9 Catering and staff dining area
9.9.1 Scope
9.9.2 Sizing
9.9.3 Other relevant guidance
9.9.4 Operational policies
9.9.5 Planning issues and options
9.9.6 Relationship to other services
9.9.7 Total quality management and interior design
9.9.8 Multi-use of space
9.10 Administration, health records and office accommodation
9.10.1 Scope
9.10.2 Other relevant guidance
9.10.3 Operational policies
9.10.4 Planning issues and options
9.10.5 Multi-use of space
9.11 Linen, sewing room and patient clothing service
9.11.1 Scope
9.11.2 Size
9.11.3 Operational policies
9.12 Supplies and stores
9.12.1 Scope
9.12.2 Other relevant guidance
9.13 Domestic services
9.14 Staff changing
9.15 Mortuary
9.15.1 Scope
9.15.2 Other relevant guidance
9.16 Engineering services, estate maintenance and communications
9.16.1 Scope
9.16.2 Sizing
9.16.3 Operational policies
9.16.4 Planning issues and options
9.16.5 Other relevant guidance

10.0 **Cost and area guidance** *page* 84

Appendix 1 – Historical background

Appendix 2 – Recently completed community hospitals

Appendix 3 – Sizing methods

Appendix 4 – Schedules of accommodation

Appendix 5 – Other relevant Health Building Notes

Bibliography

Acknowledgements

Produced for NHS Estates by Rawlinson Kelly Whittlestone (RKW) who would like to thank staff in the health authorities and hospitals listed below for their help in the preparation of this guidance; members of the working party and steering group at the Department of Health and other external advisers for their support, comments and guidance.

Particular thanks are also due to the Welsh Health Common Services Authority (WHCSA) for their help in preparing the cost guidance.

Working group (NHS Estates – Department of Health)

- Len Bartholomew – Architect – Chair
- Jane Lamb – Architect – Project Liaison Officer
- Don Eastwood – Quantity Surveyor
- Geoffrey Trubshaw – Engineer
- Mrs Pat MacDonald – Nurse Planner (succeeded by Ken Wood)
- Ken Wood – Nurse Planner, seconded from Trent RHA
- Maria Murray – Team Secretary

Steering group (NHS Estates/NHSMR – Department of Health)

Working group members plus:

- Dr Michael Lee-Jones RCGP Representative
- Ray Greenwood – Nursing Officer
- Dr Vivienne Press – Senior Medical Officer
- Dr Michael Prophet – Senior Medical Officer
- Kay East – Physiotherapist seconded from the NHS
- Pam Green – Priority Health Services
- Valerie Weeks – Nursing Officer

External advisers for guidance on specific services:

- Tony Jones – District Physiotherapist, Eastbourne HA
- Susan Whiting – District OT, Oxford HA
- Olive de Ville – District Superintendent, Radiographer, Bloomsbury and Islington HA
- Brian Frost – External catering adviser
- Dr Peter Strangeways – Association of General Practitioner Community Hospitals

Hospitals and health authorities:

- Blyth Community Hospital
- Bridlington Community Hospital
- Ilkeston Community Hospital
- South Molton Community Hospital
- Jarrow Community Hospital
- Bolsover Community Hospital
- Blandford Community Hospital
- Ystradgynlais Community Hospital
- Mold Community Hospital
- Welsh Health Common Services Authority
- West Midlands RHA
- Bath HA
- Cornwall HA
- Herefordshire HA
- Portsmouth & SE Hampshire HA

Photographs in the text

Cover (detail) and main photograph – Chirk Community Hospital
Photo: WHCSA

Photographs by RKW unless otherwise stated

4. South Molton Community Hospital

5. Mold Community Hospital
Photo: WHCSA

8. Ystradgynlais Community Hospital
Photo: WHCSA

9. Blyth Community Hospital
Photo: Trent RHA

10. Ilkeston Community Hospital

14. Location in the community
Photo: WHCSA

15. Mold Community Hospital
Photo: WHCSA

16. Ilkeston Community Hospital
Photo: Trent RHA

22. Gardens – Ystradgynlais Community Hospital
Photo: WHCSA

23. Courtyard – Ilkeston Community Hospital

24. Ward corridor – Ystradgynlais Community Hospital

26. Day hospital courtyard – Lambeth Community Care Centre

42. Physiotheraphy exercise area – Lambeth Community Care Centre

44. Physiotherapy exercise area – Ystradgynlais Community Hospital

48. ADL kitchen – Lambeth Community Care Centre

60. Main entrance – Lambeth Community Care Centre

61. Reception – Ystradgynlais Community Hospital

62. Main waiting – Bridlington Community Hospital

63. Central atrium – Ystradgynlais Community Hospital

65. Staff dining room – Blyth Community Hospital

1.0 Introduction

Over the next ten to fifteen years, both organisational and technological changes will have a significant impact on the way that the future health services are provided. There will be scope for a radical shift from care in acute hospitals, to care in community and primary care settings and in people's homes. New and innovative models of community health facilities will be needed as a response to these challenges.

With the increased emphasis on health promotion, the need for resource centres to support home care, and increased interagency co-operation in the provision of community services, renaming of community hospitals to do justice to their scope and role may well be appropriate.

Community hospitals already provide a wide range of services. The essence of community hospitals is their diversity, and their potential to respond flexibly to differing local needs and changing circumstances.

Community hospitals have many advantages. The circumstances prompting their development may vary considerably from district to district. Some districts see community hospitals primarily as a means of extending services to elderly people, others as developing services for the whole community, yet others as part of an integrated service linked to and in support of acute hospital and primary care services.

1.1 Aims of document

The aims of this Design Guide are to:

- define and promote the concept of community hospitals
- encourage innovative development of community services and community hospital designs
- provide planning and design guidance specific to community hospitals
- collate and disseminate experience from other projects and from evaluations
- promote good practice and warn of pitfalls
- identify other relevant guidance material.

1.2 Audience

The guidance in this Design Guide is of relevance to:

- District Health Authorities (DHAs), Family Health Service Authorities (FHSAs), GP Fund Holders (GPFHs) – as purchasers of community health services, other GPs, and also local authorities as purchasers of social care services
- DHAs, Units, NHS Trusts and the private sector, as providers of community health services
- Project teams (PTs) and design teams (DTs), as planners and designers of community hospitals
- Voluntary groups and consumers.

1.3 Structure of guidance

Chapter 2 focuses on the concept, scope and role of community hospitals and their potential benefits.

Chapters 3–10 deal with service planning, whole hospital planning, planning and design for individual services, and cost and area guidance.

Guidance in this document covers community hospitals, and their possible integration with GP surgeries and community health clinics. It does not cover residential facilities for elderly, mentally ill or people with learning difficulties.

Diagram 1 indicates which Chapters are likely to be of interest and relevance to each of the above audiences.

1. Guide to contents

		Audience			
Chapter	Topic	DHAs/FHSAs GPFHs Purchasers	DHAs/Units NHS Trusts/GPs Private Sector Providers	PTs/DTs Planners/ Designers	Voluntary organisations/ Consumers Users
2	Concept and philosophy	×	×		×
3	Service planning issues and options	×	×		×
4	Assessment of demand and "sizing"	×	×	×	
5	Quality of environment	×	×	×	
6	Location and site selection	×	×	×	
7	Whole hospital planning issues			×	
8	Whole site operational policies			×	
9	Planning individual services			×	
10	Cost and area guidance		×	×	

× = of particular relevance

2.0 Concept and philosophy

2.1 What is a community hospital?

A community hospital provides a range of services to patients living locally, who do not need the specialist services and facilities available in an acute hospital.

Services may include:

- inpatient services – acute, rehabilitation, respite care
- day/treatment facilities, minor surgical procedures
- day hospitals
- rehabilitation services
- clinic services – run by GPs, consultants and other professionals
- minor casualty
- diagnostic services
- resource base for community health staff.

These services may cater for a variety of different patient care groups including:

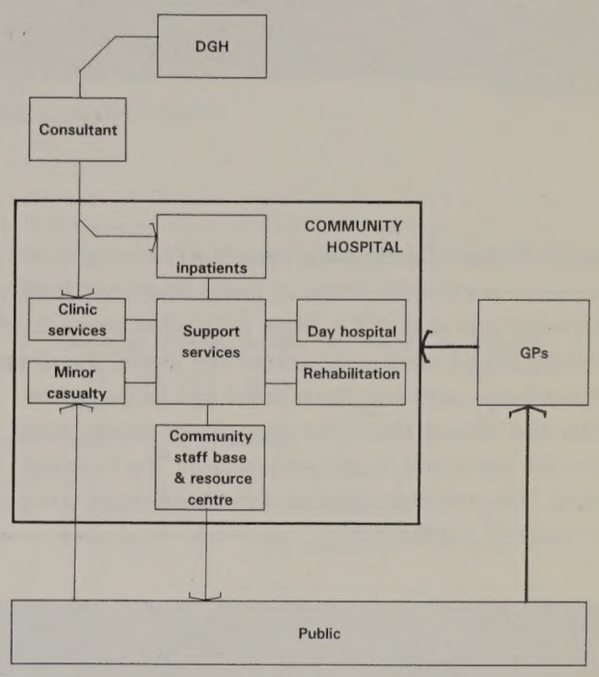
- acute
- elderly
- mental illness – adult acute and elderly
- maternity
- terminal illness
- younger disabled.

The range and mix of services provided for each care group will vary according to local needs and the availability of other services. The essence of community hospitals is their diversity, versatility and flexible response to local requirements. (See Chapters 3 and 9).

A community hospital should be an integral part of the health care system in a district, providing an extension to primary care services and a source of referral to and from acute hospital services. Patients may be under the care of GPs, consultants or nursing staff.

With implementation of the proposals outlined in the White Paper 'Caring for People', local authorities will become responsible for the provision of all social care from 1993. Community hospitals may, therefore, also wish to enter into arrangements with local authorities interested in making use of their facilities.

The relationship between a community hospital and other health care services is represented diagrammatically in Diagram 2.



2. The community hospital in its context

Community hospitals have their origins in the cottage hospital, which first developed in the late 19th century. A brief historical background to community hospital development is provided in Appendix 1.

The last decade has resulted in a significant number of new purpose built community hospital developments. The average size of these new developments is larger than noted in a previous survey*. Their functional content is set out in Appendix 2.

Brief descriptions of five of these recent developments illustrate clearly their variety and diversity of provision and the inappropriateness of a single community hospital "blueprint".

* **Footnote.** 'The role and function of community hospitals.' H. Tucker, Kings Fund Project Paper No. 70, 1987.

3. Functional content of five hospitals

Hospital	District	Year open	Beds				Other services						
			Total	Consultant		GP acute	Day hosp.	Minor casualty	Operating theatre	X-ray	GP premises on site	Rehab	Clinic services
				Elderly	EMI								
South Molton	N. Devon	1987	28	17*		11	1	×				×	×
Mold	Clwyd	1984	40	20*		20	1	×		×		×	×
Ystradgynlais	Powys	1985	52	30	8	14	1	×		×		×	×
Blyth	Northumberland	1987	78	38	14	26	2	×		×	×	×	×
Ilkeston	S. Derbyshire	1987	92	48	20	24	1	×	×	×	×	×	×

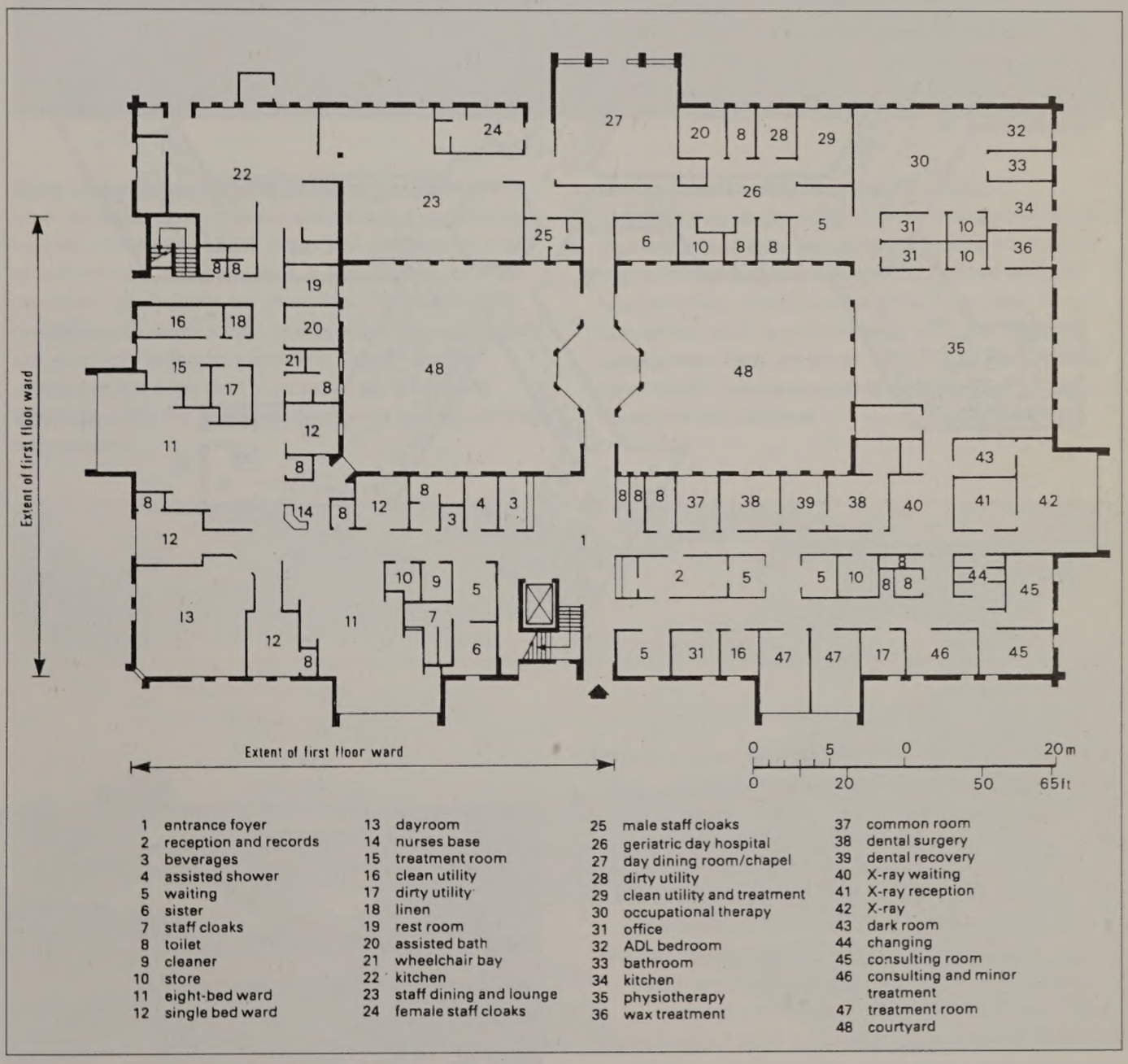
×=present *managed by GPs

South Molton Community Hospital (28 beds) is one of a series of community hospitals being developed to serve this large rural area. It is a single storey development with a single 28 bed ward and incorporates shared use of space between the ward and day hospital and between the latter and rehabilitation. The ward design breaks away from the traditional acute ward pattern. The four-bed rooms, which have ensuite sanitary facilities, are grouped to maximise patient privacy.

4. South Molton Community Hospital

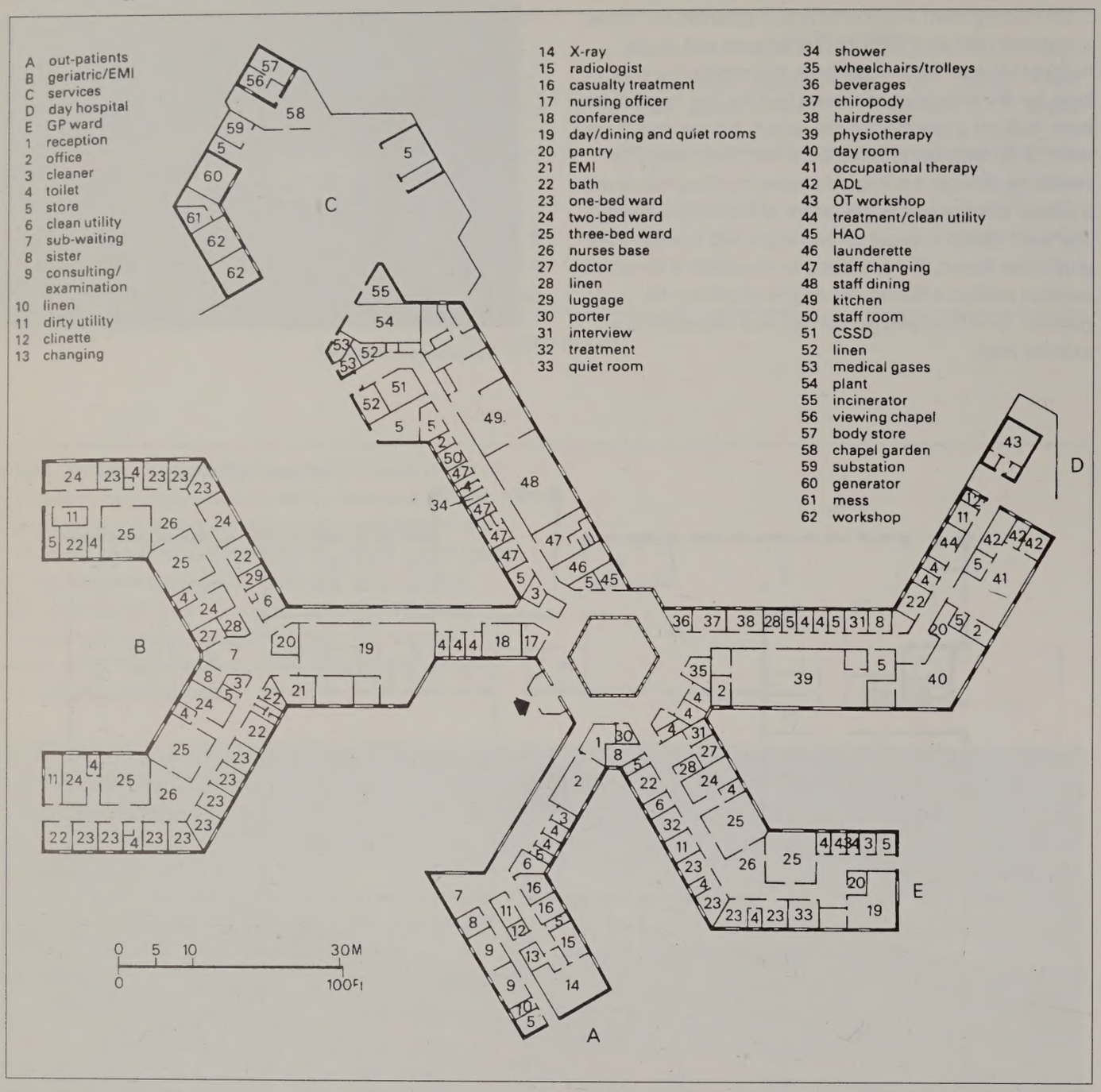
Mold Community Hospital (40 beds) is situated in a small country town and the services it provides are closely integrated with local primary care services and acute hospital services. Both acute beds and continuing care beds for the elderly are managed by GPs. The hospital has been built on a constrained site, which has resulted in one ward of 20 beds being provided at first floor level. The remaining services are located around two courtyards with a central corridor across the centre of the development. The ward design is based on two eight bed echelon bays plus single rooms, the aim being to maximise observation but also provide a reasonable degree of privacy for patients. One courtyard is intended as a physiotherapy exercise area.

5. Mold Community Hospital



6. Plan of Mold Community Hospital

7. Plan of Ystradgynlais Community Hospital



Ystradgynlais Community Hospital (52 beds) is situated in an isolated location and serves an area with high unemployment and heavy industry health problems. Because of its remote location and the lack of a DGH in Powys, it is more self-contained than most community hospitals. The consultant lead services for elderly and elderly mentally ill patients include local assessment services, as well as rehabilitation and continuing care. The finger plan whole hospital shape provides convenient access for all departments, to the central entrance reception area. The ward design uses fixed furniture in the four-bed bays to create a domestic environment and to maximise patient privacy. The site has been sculptured (with earth mounds) and landscaped to provide an attractive exterior environment and to shelter the development from prevailing winds.

8. Ystradgynlais Community Hospital

9. Blyth Community Hospital

Blyth Community Hospital (78 beds) is situated in a small industrial town. It uniquely combines a community hospital, community health clinics and surgeries for 3 GP group practices under one roof. It also contains an acute psychiatric day hospital for under 65s. The hospital is a predominantly single storey development on a constrained site, with little scope for expansion. The GP ward is situated at first floor level. Courtyards are attractively landscaped and are used both by patients and for housing hospital pets.

Ilkeston Community Hospital (92 beds) is a predominantly single storey development, serving a rather deprived urban area. The operating theatre is used on a regular basis by visiting consultants. A clearly defined hospital street, sometimes loaded on both sides, on one side, or not at all, is much in evidence in this larger development. Here art works, by GCSE art students and other artists, have been used to creative effect in both courtyards and corridors.

10. Ilkeston Community Hospital

Even from this small number of examples, it is clear that planning and design of community hospitals, both now and into the future, raises many issues. What range of services is appropriate in a particular locality? How can these services be appropriately sized to meet varying local needs? What future pressure to expand, develop or diversify, should be anticipated?

There are also aspects of whole hospital planning like departmental relationships, communication systems, expansion strategies, etc, which are crucial to the overall functioning of the building, but which require a different response from that which is appropriate for larger acute hospitals. Hospital streets and long blank corridors seem somehow misplaced in a community hospital setting. At a departmental level, privacy and confidentiality are arguably even more important here, where staff and patients are more likely to know each other, than in a more anonymous acute hospital setting. Adoption of standard acute wards may represent a missed opportunity to create a more appropriate and less clinical environment for inpatient care.

Interagency co-operation between the health authority, local authority and voluntary agencies, can be fostered in community hospitals by shared and multi-use of space. This enables a variety of compatible space requirements to be accommodated effectively in an economical building envelope.

The quality of both interior and exterior environments can also make a major contribution to the positive image and friendly, reassuring and welcoming atmosphere that community hospitals seek to engender.

2.2 What is the future role of community hospitals?

If community hospitals are to develop their role as an integrated part of the healthcare system, they need to present their image and capabilities positively, so that their contribution can be properly understood and their future potential fully exploited.

Contracting for services may result in greater clarification and understanding of the role of community hospitals.

A wide range of services is already provided in community hospitals. Many existing community hospitals have plans to develop their existing services or add new services.

There is a variety of factors which may further extend the future role of community hospitals:

- **Technological change:** this will create scope for more diagnostic, treatment and care activities to be provided in low tech settings, away from acute hospitals.
- **Increases in home care:** this will generate a need for local resource centres to support it.
- **Increased emphasis on health promotion and screening activities:** a community hospital can be a useful focus for these activities within a community.
- **Implementation of the NHS and Community Care Act 1990:** this may result in an increased need for access to community hospital services.
- **Increased cost consciousness:** White Paper implementation, the purchaser/provider split, contracting and capital charges will all raise questions about which services need to be provided in the more expensive "high tech" acute hospital settings and which services could be provided elsewhere.
- **GP preferences:** GPs may choose to retain care of more patients in community hospitals, if such facilities are available.
- **Interagency co-operation:** there may be increased scope for joint provision of community services between the health authority and local authority, voluntary agencies and the private sector.
- **Consumer expectations:** increased consumer expectations may create pressure for more locally accessible facilities.

2.3 When is community hospital development appropriate?

The development of community hospitals can be an appropriate response to a variety of health authority priorities arising from a needs based assessment of local service requirements.

2.3.1 Integration and decentralisation

A DGH plus a network of community hospitals can provide an integrated service which makes best use of both types of services and facilities and provides "appropriate care in appropriate places".

Centralised acute services based on acute hospital care may not be feasible in some health authorities because of geography, long travel distances, and poor communications.

Community hospitals are appropriate, not only for rural areas, but also for densely populated urban areas with poor housing and poor family support.

2.3.2 Rationalisation

New community hospitals may replace hospitals which are too small to be viable, inappropriately located, or provide substandard unsuitable accommodation.

2.3.3 Expansion of services for elderly people and whole population

Community hospitals provide an opportunity to expand the total quantity of health care provision in a health authority, for example:

- to create or improve local provision for rehabilitation services, particularly for elderly people;
- to cater for the needs of the whole population in expanding towns.

2.3.4 Flexible response to change

Provision of community hospitals, integrated with primary care and acute hospital care, may create a pattern of service provision which can respond more flexibly to changes in service patterns, brought about by demography or technological change, than the centralised provision of all acute services on a single large DGH site.

2.4 What are the benefits of community hospitals?

The checklists below outline possible benefits of community hospitals to units, NHS Trusts, GPs and other staff, and to patients and visitors.

2.4.1 Benefits for patients

The benefits for patients relate to:

- **Quality of care:** earlier discharge and better coordinated follow-up care for selected patients discharged from a DGH. Continuity of care for patients admitted by GPs. Better co-ordination of nursing care by community hospital nurses and community nursing staff.
- **Access:** community hospitals maximise accessibility of services to consumers, by providing care and treatment as close as possible to peoples' homes. Unnecessary and costly travel time for patients and relatives is also reduced.
- **Environment:** this can be more appropriate to the type of care offered, with greater scope for "humanisation", than is possible in an acute hospital setting.
- **Contact and family support:** provision of rehabilitation services in community settings allows for increased contact with, and possible care involvement by relatives.

  Community hospitals are a good base from which to provide support to families. Staff can get to know the families as well as the patients.
- **Health promotion:** community hospitals can provide an important focus for health promotion and screening for the local communities served.

2.4.2 Benefits for staff

The benefits for staff relate to:

- **Job satisfaction:** community hospital provision can maximise GPs' contribution to health care, by providing an enhanced role for GPs, in terms of testing, diagnosis, monitoring and care of inpatients. This, in turn, can provide better continuity of care for patients and increased job satisfaction for GPs.

Improved contact between hospital and community nurses, resulting from shared care of patients, provides a greater awareness of the social circumstances and progress of individual patients. This can also increase job satisfaction for those concerned.

- **Professional interchange:** participation by consultants in community hospital activities can improve the quality of care provided by GPs, because of the opportunities to exchange professional views and directly seek specialist advice. There is also a reduction in professional isolation for GPs and nurses. Community staff may have increased access to other professionals.

  The outposting of consultant outpatient clinics and consultant managed beds in community hospitals creates the opportunity for increased contact and cooperation between GPs and consultants, to the benefit of both staff and patients.

- **Extended roles:** community hospitals can provide the opportunity to develop innovative methods of service provision which may create extended roles and responsibilities for nursing and therapy staff. It is not just a question of decentralising existing acute hospital services, but of organizing services and staff in a different way, for example, by developing the role of the nurse and encouraging the development of nurse managed beds.

  Provision of minor casualty services may reduce the "casual patient" workload on acute hospitals, provide a further opportunity for GPs to exercise their skills, and reduce travel distances for patients.

2.4.3 Benefits to DHAs, Units and Trusts

The benefits to DHAs, Units and Trusts relate to:

- **Appropriate use of resources:** maximum use of community facilities can remove unnecessary pressures from acute hospitals, reduce bed blocking and, where new acute developments are proposed, may reduce the scale of acute provision which wil be required.

  The provision of "appropriate care in appropriate places" can reduce service overheads, as inexpensive services will no longer be provided in expensive settings.

  Decentralised provision of outpatient services can reduce pressures on and cost of patient transport services.

  There may be lower non attendance (DNA) rate of outpatient appointments in community hospitals, than in acute hospitals, resulting in less wasted resources.

- **Flexibility and versatility:** decentralised services, consisting of an acute hospital supported by a network of community facilities, are likely to provide a more flexible response to future changes in health care patterns, than a more centralised pattern of provision.

- **Capital investment:** provision of community hospitals, will result in capital projects which are smaller, and easier to manage than larger acute hospitals.

- **Community involvement:** community hospitals provision may generate increased community participation and increased financial support from voluntary organisations.

2.5 What are possible concerns about community hospitals?

The checklists below note some of the concerns expressed by staff and providers about community hospitals.

2.5.1 Concerns of staff

Concerns for staff include:

- **Travel time:** consultants may be concerned about increased travel time and their lack of availability for emergencies at the DGH. These issues may possibly be ameliorated by careful timetabling and organization of emergency cover.

- **Commitment:** decentralised service provision is dependent upon the commitment of local GPs, their willingness to put in time caring for their patients in community hospitals and on appropriate remuneration for services provided.

- **Recruitment:** in some rural areas, nurse recruitment may be difficult.

- **Staff training:** if decentralised provision becomes more common, there will be a long term need for training of nurses, doctors and paramedics, to reflect this changed pattern of services. GPs may also wish to develop specific skills*. In the short term, possible lack of experience and variety for training purposes may need to be dealt with by rotation of staff between different health care settings.

---

* **Footnote.** The Royal College of General Practitioners; Educational needs of doctors working in community hospitals; a report prepared for the Education Committee of the Royal College of General Practitioners. Journal of Royal College of General Practitioners 26: 461–5. 1976.

2.5.2 Concerns for DHAs, Units and Trusts

Concerns for DHAs, Units and Trusts include:

- **Duplication of equipment:** careful assessment will be required of what equipment it is appropriate and cost effective to provide in a community setting. Service overheads will increase with the provision and maintenance of more expensive equipment.

- **Underuse of staff:** where the workload is insufficient to enable a service to be provided reasonably efficiently and economically, it may be necessary either not to provide the service at all, or to consider a more intermittent, or where appropriate, a mobile pattern of provision.

- **Bed blocking:** beds may become blocked by long stay elderly patients. To avoid this, it will be necessary to have clear admission and length of stay policies, in order to maintain reasonable throughput in the majority of beds and safeguard the ethos of a community hospital.

- **DGH referral:** occasionally, there may be a need for access to specialist services and to move patients in the event of complications. Clear admissions policies should help to reduce the incidence of such problems.

3.0 Service planning issues and options

3.1 Range and mix of services

Services provided in community hospitals fall into the following broad groups:

- inpatients
- day/treatment facilities, minor surgical procedures
- day hospital facilities
- rehabilitation services
- clinic services – consultants, GPs, health authority clinics
- minor casualty
- diagnostic services
- health promotion services
- resource base for community health staff
- educational support
- general support services

Figure 11 overleaf shows the wide range of services that are currently being provided in community hospitals.

3.2 Key service planning issues

Key service planning issues include:

- provision of services primarily for elderly people or for the whole community. This will influence both the range of services provided and the demands on physiotherapy, radiodiagnostics, out-patients, etc.
- range and type of services to be provided for each care group.
- selection of an appropriate mix of services to suit local needs, allowing for the age structure of the population, local factors affecting morbidity patterns and the location of other health facilities.
- the distance from the nearest DGH may influence service provision.
- new models of care may be appropriate in community hospitals, e.g. nurse managed beds.
- the need to anticipate the likely future role of community hospitals:
  - (i) possible increases in minor operations, treatments, endoscopies and other investigative procedures.
  - (ii) increased demand for elderly and EMI services
  - (iii) developments in out-patient and clinic services
  - (iv) increased need for a resource base for community staff to support home care
  - (v) increasing focus on health promotion and disease prevention; provision of space for local self-help and support groups.

3.3 Viability and scope of particular services

Services will be affected as follows:

- provision of inpatient and casualty services will be heavily dependent upon strong GP support and commitment.
- provision and viability of a basic radiodiagnostic service will be dependent on the scope and scale of other services to be provided (especially out-patients, minor casualty, inpatients). (See Chapter 4 – Assessment of demand and "sizing" of services).
- occupational therapy and physiotherapy will provide services for inpatients and day patients and physiotherapy also for out-patients and direct GP referrals. Speech therapy will also provide services to outpatients and day patients.
- provision of maternity services is likely to be restricted to ante-natal and post natal clinics and care of post natal lying-in patients discharged from the DGH. In particular, local circumstances (e.g. where local populations are geographically isolated from the nearest DGH) and where GPs have appropriate experience and enthusiasm, provision of GP maternity services for low risk consultant screened patients may be justified. The viability of these services in terms of capital costs, staffing and likely subsequent use of facilities will need to be carefully assessed.

- surgical services will generally consist of consultant out-patient clinics, and pre-convalescent care of post operative patients discharged from the DGH. Clinic services may also include provision for treatment/endoscopy sessions and minor surgical procedures carried out by consultants or by GPs. Whilst operating theatres will not generally be provided in new community hospitals, there are existing community hospitals with a long established tradition of providing surgical services. If the operating facilities in these hospitals require upgrading, or replacement as part of a redevelopment scheme, appropriate guidance can be found in Health Building Note 26 – 'Operating department'.

- provision of pharmacy, pathology, and sterile supply services will normally be from the DGH. Local provision is generally not cost effective.

3.4 Relationship with community health clinics and primary care services

Health centres, or GP practice premises, may be provided on the same site, or as part of a community hospital development. Where this is possible the advantages are:

- ease of access for GPs to inpatients and minor casualty

- possible shared use of support spaces between GP surgeries, out-patient clinics and community health clinics

- access by patients to a range of services on one site

- potential for improved communication between hospital and community staff

Planning of such integrated facilities should take note of guidance on General Medical Practice Premises and community health clinics provided in Health Building Note 46 (in preparation).

3.5 Interagency co-operation

There is a likelihood of increasing co-operation between health authorities, local authority social services (LASS), voluntary organisations and the private sector, in the provision of services and facilities in community-based settings. For example:

- joint health authority and local authority provision for day hospital and day centre accommodation for elderly people

- sessional use of community hospital day hospital accommodation for Macmillan day hospitals for terminally ill patients and incorporation of Macmillan beds into a community hospital.

The prerequisites for successful interagency co-operation include clear management arrangements and the establishment of contracts for service provision.

11. Checklist of potential community hospital services

Inpatient
- GP medical cover:
- respite care – progressive diseases
- terminal care
- minor acute – chest, urinary infections
- stabilisation of diabetic patients
- intensive treatment of varicose ulcers
- pre-convalescent care, rehabilitation (after DGH episode, minor stroke, etc)
- HIV positive, AIDS – convalescent, respite, terminal care.

- Consultant cover:
  - geriatric
  - EMI

  } assessment, rehabilitation, respite care, continuing care

- Nurse managed beds:
  - patients requiring 24-hour nursing care

Radiodiagnostics
- basic procedures
- ultrasound

Rehabilitation
- Physiotherapy – inpatient, outpatient, day patients, GP referrals and domiciliary services
- OT – inpatient, day patients
- Chiropody
- Speech therapy

Consultant out-patients
- General surgery
- General medicine
- Geriatrics
- Rheumatology
- Dermatology
- Audiology, hearing aid
- Opthalmology
- Paediatrics
- Psychiatry
- Gynaecology
- Obstetric, ante natal
- Diabetic
- Orthopaedic
- ENT
- Oncology

GP/Primary health care team (PHCT)
- GP surgery sessions
- Cytology, cervical screening
- PHC for homeless, drug users
- Computer links to DGH for:
  - requesting tests/receipt of results
  - making OPD appointments
  - obtaining bed state information
- Ante natal clinics

Day hospital
- Elderly
- Adult mentally ill
- EMI
- Terminally ill

Treatment/screening etc
- Minor casualty
- Treatment/Investigation sessions:
  - blood taking
  - injections
  - eye/ear treatments
  - dressings
  - blood pressure
  - ECG
  - chiropody
- Screening
  - breast screening
  - smokers
  - osteoporosis
  - diabetic retinopathy, diabetes
  - high blood pressure
- Procedures:
  - minor surgical procedures
  - endoscopies
- Dentistry

Community health clinics
- Family planing, Well Women
- Antenatal relaxation, /parentcraft
- Keep fit
- Chiropody
- Child health surveillance – infant welfare, development assessment, immunisation
- Community dental service
- Health education
- Dietetics
- Speech therapy
- Hypertension
- Obesity
- Diabetes
- Child and family service, therapy
- Surgical appliances
- Orthoptics

Support services
- Health records
- Administration
- Catering
- Supplies, storage
- Mortuary
- Domestic services
- Waste disposal
- Building, equipment, engineering maintenance
- Engineering services operation

Teaching
- Consultant, junior medical staff
- Consultant, GP interchange
- GP, medical students
- Nurse training
- Community staff training
- General staff training

Staff base
- District nurses
- HVs (PHCT)
- CPNs
- Practice nurse (PHCT)
- Social workers
- OTs, physios, community physios
- AIDS community care team
- Dietitians
- Chiropodists
- School nurses
- Continence advisor
- (Diabetic support nurses)
- (Terminal support nurses)
- (Clinical psych/psychoth)
- (Speech therapists)
- (Resource team for MH)
- Interpreters
- Community midwives (PHCT)
- (Voluntary groups)

( ) sessional base only

4.0 Assessment of demand and "sizing" of departments

A key characteristic of community hospitals is variety, in the range of services they provide and in the size and scale of these services. This feature reflects and underlines the role which a community hospital has in meeting local needs.

There is, therefore, no blueprint for a community hospital and providers, in drawing up plans for new community hospitals, will need to select those services which meet their local needs and the requirements of purchasing authorities. They will also need to decide on the most appropriate scale of provision for each service.

Diagram 12 illustrates some possible combinations of services. The functional content of these four examples (A,B,C,D) generally increases in size from A to D. Example A contains relatively few beds and day places with minimal clinical support facilities, while D contains more beds, a larger out-patient department and a two-room radiodiagnostic department.

Diagram 12 merely illustrates the range of services and sizes of services that may be provided. It does not imply, for example, that a small hospital would never contain a radiodiagnostic service. A smaller community hospital will not necessarily contain only small services. For example, a 28-bed hospital may have a 40-place day hospital and a large out-patients or community clinic area. It will depend on the scale and mix of services which are most appropriate for a particular locality.

Planners and providers of community hospital facilities will need to "pick and choose" from a list, such as this, in order to identify the range and scale of services appropriate to their local needs. The cost and area guidance provided in Chapter 10 and in Appendix 4 illustrate how this can be done.

When services are being planned in detail, there may also be choices to be made concerning the type and mix of space provision for a particular service. For example, for physiotherapy, it will be necessary to decide on the amount of space to be dedicated to exercises, the number of treatment cubicles required and whether the provision of a gymnasium is justified. The detailed guidance on sizing provided in Chapter 9 includes suggestions on how such issues can be dealt with.

Services	A	B	C	D
Inpatient services				
GP acute beds	20	20	30	30
Consultant elderly beds	20	20	40	70
Consultant EMI beds	–	10	20	20
Total beds	40	50	90	120
Day patient services				
Elderly day hospital places	15	20	20	25
EMI day hospital places	*	*	20	20
Total day place	15	20	40	45
	*Combined with Elderly DH			
Clinic services				
OPD (C/E rooms)	2	2	4	6
Minor casualty (dept)	1	1	1	1
Dental dept (suite)			1	1
Endoscopy suite			1	1
Main entrance	1	1	1	1
Clinical support services				
Rehabilitation (dept)	*	1	1	1
X-ray – RDR		1	1	1
– Ultrasound room			1	1
Operating suite (suite)				1
Pharmacy, dispensing (dispensary)				1
	*Included in day hospital			
Ancillary services				
Catering: main kitchen (meals)	78	99	183	324
Catering: staff dining (places) meals	20	25	45	60
Mortuary: body store & viewing room (spaces)	3	3	6	6
Linen & sewing room (dept)	1	1	1	1
Domestic dept (dept)	1	1	1	1
Supplies & distribution (dept)	1	1	1	1
Central staff change	1	1	1	1
Works dept –				
– boiler house/work-shop/stores	1	1	1	1
– Emerg. generator/elect. intake	1	1	1	1
– Waste disposal	1	1	1	1

12. Typical examples of functional content

5.0 Quality of environment

5.1 Philosophy of care

Community hospitals provide the opportunity for:

- a more holistic approach to patient care
- a focus on caring for patients within their own community
- continuity of care of patients by their GPs.

5.2 Ethos of environment

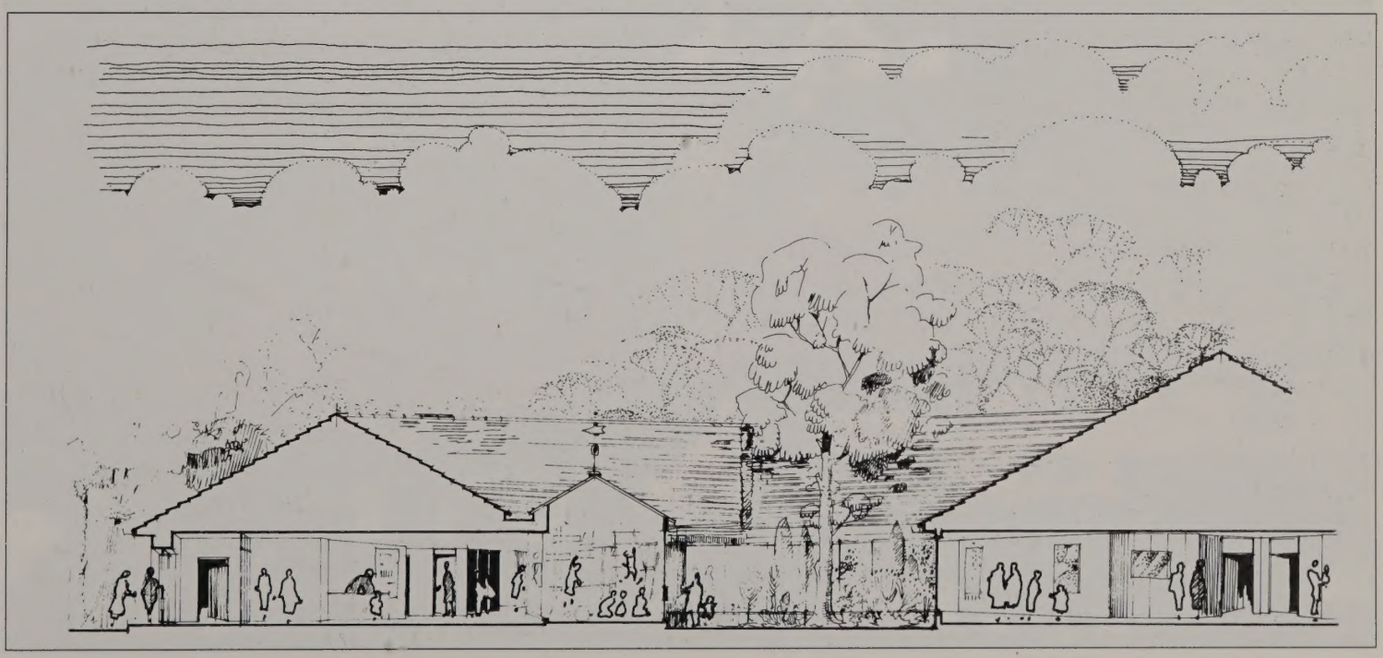
The buildings provided should:

- be on a scale appropriate to the range and type of services being provided; preferably single storey or a maximum of two storeys, with a ground floor location, where possible, for patient areas
- be in a style appropriate to the local context, with appropriate use of local materials and architectural styles, to blend buildings into their environment
- incorporate landscaping, which provides an attractive image and outlook, and safe and usable exterior spaces
- focus on the creation of a non-clinical domestic style interior environment, which is welcoming and reassuring
- exploit use of colour, pattern, texture, lighting and art to maximum effect
- ensure that choice of furniture enhances, rather than detracts, from the interior environment and represents an appropriate balance between function and aesthetics.

5.3 Total quality management

Operational policies and the design of the buildings should combine to ensure appropriate:

- **Privacy:** in bed areas, sanitary facilities and treatment areas
- **Confidentiality:** in reception, consulting and treatment areas
- **Dignity:** in all patient areas
- **Choice:** of activities or spaces
- **Control:** of temperature, personalisation of bed spaces, scope for relatives to care for patients
- **Independence:** provision of facilities which encourage independent use by patients
- **Access:** both into and around the hospital for patients and visitors in wheelchairs, and those with reduced mobility and/or sight impairment.



13. View through the main entrance and internal courtyard showing the scale and quality of environment

6.0 Location and site selection

Careful choice of a suitable site will be crucial to the success of a community hospital. The following are important factors to be considered in selecting a site.

6.1 Accessibility

To fulfill their role as part of an integrated health care system, community hospitals should be distributed and sited to provide coverage of, and access by, the local population they are intended to serve. Community hospitals may serve urban, semi-urban or rural populations. The catchment area of a community hospital will be determined by the contracts taken out by DHAs or fund-holding GP practices, on behalf of their residents and patients. GPs may be reluctant to use community hospitals which are an appreciable travel distance from their surgeries.

The site should be located, either close to the centre of population served, or easily accessible via public transport.

Site selection should not only be restricted to sites already owned by the health authority, as these may not always be appropriately located.

6.2 Physical site characteristics

Restricted sites may make it difficult to provide the majority of patient areas at ground floor level and may provide little outdoor space, or scope for landscaping.

Sloping sites may also result in the need for steps within the building and a first floor location for some functions. Sites should allow some scope for expansion, even if none is initially envisaged.

A site which provides external interest, stimulus and a sense of being part of the community has advantages particularly for longer stay patients and those attending the day hospital.

Sites should allow provision of adequate car parking, access by ambulance transport and for supply of goods and disposal of waste.

6.3 Relationship with primary care facilities

If a health centre or GP surgery is to be included as part of the development, site selection may need to cater for separate access to each part of the building and for additional car parking requirements.

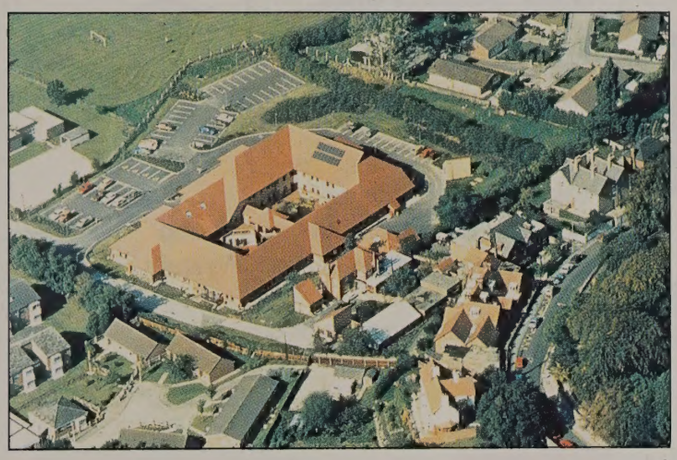
14. Location in the community

7.0 Whole hospital planning issues

To provide an appropriate environment which reflects the quality criteria outlined in Chapter 5, whole hospital design strategy should consider the following issues.

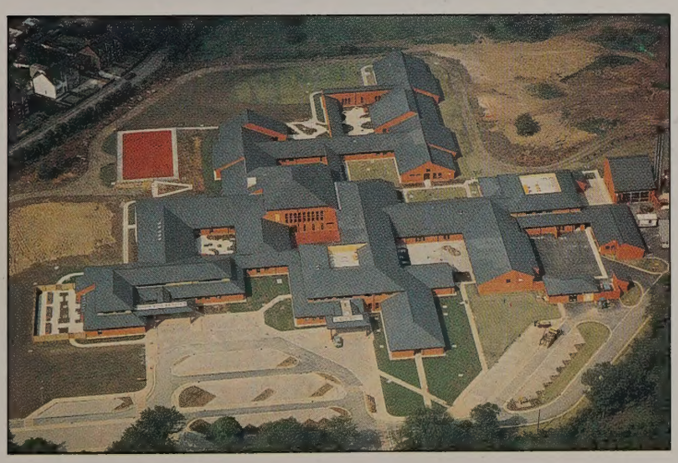
7.1 Scale and style

Either new buildings or adaptation of existing facilities may be appropriate, as a means of providing accommodation which is suitable for modern health care requirements.



15. Mold Community Hospital

A single storey development is preferable to preserve a domestic scale. This may, however, create a conflict between locating patient services at ground floor level, and keeping the whole development reasonably compact, with short travel distances between related services. Two storey development may be appropriate for some sites and sizes of hospitals.



16. Ilkeston Community Hospital

Separation of whole hospital traffic from departmental traffic is not as important as in an acute hospital. Boundaries between services are more blurred in a community hospital.

7.2 Integration with other facilities

Provision of a community hospital, in association with a health centre or GP premises, may result in some economies of space provision, through shared use of support services. Integration may also affect the groupings of services on the site. Where facilities are integrated, provision will be required for health education and promotion activities.

7.3 Zoning and relationships between services

The smaller scale of community hospitals generates different requirements for relationships between services compared to an acute hospital. Diagram 17 summarises these requirements, which are shown diagramatically in Diagram 18.

Occupational therapy (OT) and physiotherapy should be accessible to the whole hospital and to patients coming in from outside.

OT, physiotherapy and day hospital accommodation (including speech therapy and chiropody) will generally be grouped together at ground floor level, close to the main entrance. This grouping provides easy patient access between services. Care should be taken to provide direct access for inpatients to specific day hospitals facilities (e.g. hairdressing), rather than access via the day hospital.

There are differing views on whether inpatient services for the elderly should be physically linked to, or separate from, day hospital and rehabilitation services. This will be dependent on operational policies for use of day hospital services by inpatients, provision made for OT and physiotherapy on wards and on rehabilitation staffing policy.

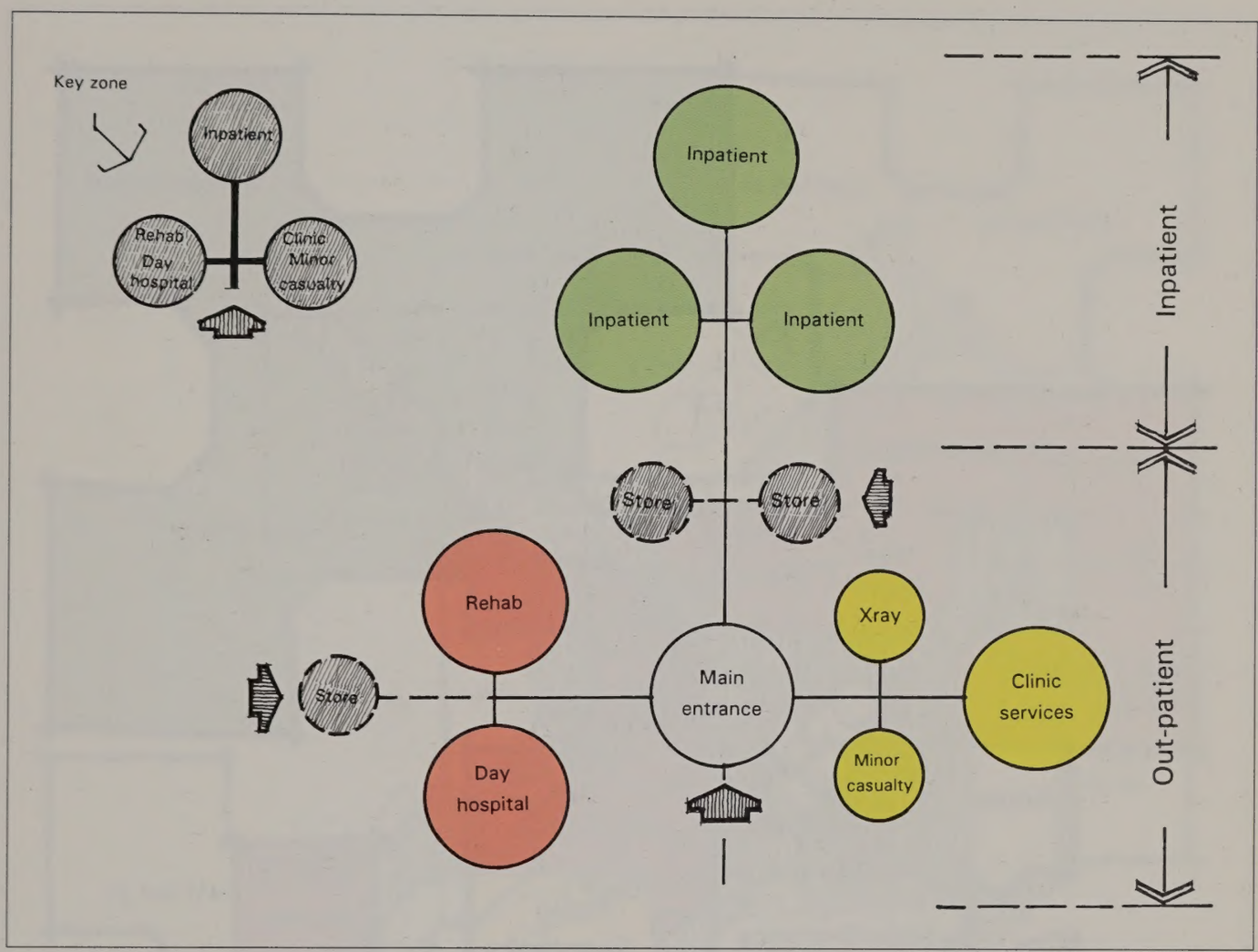
Minor casualty, outpatients and radiodiagnostics are generally small and sometimes single-handed departments. Physical grouping of these services allows for some sharing of support spaces (e.g. utilities and waiting areas) and shared use of nursing staff. Reasonable proximity between minor casualty and one of the inpatient wards may also facilitate provision of night-time nursing cover for minor casualty by the ward night staff. Separate access to minor casualty is not generally required.

Inappropriate juxtaposition of departments (e.g. mortuary next to outpatients) should be avoided. As far as possible,

17. Departmental relationships

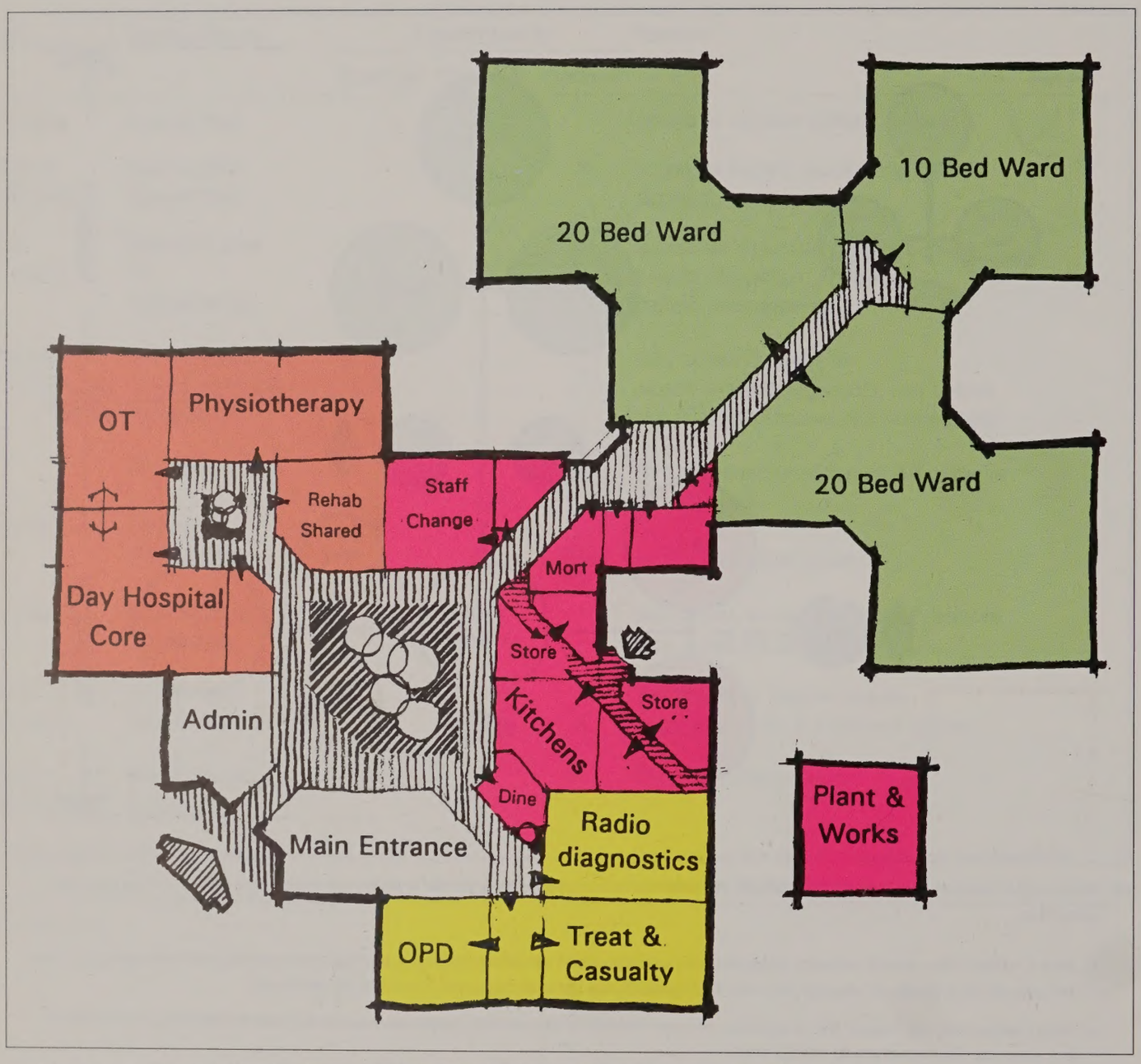
Dept	Relationship to	Close Proximity			Reasons
		Essential	Desirable	Optional	
GP beds	Ground floor		×		Access to outdoor space
Elderly/ EMI beds	Day hospital			×	Scope for shared use of nursing staff
	Ground floor		×		Access to outdoor space
Day hospital	Main entrance	×			Access for day patients from outside
	OT	×			Ease of day patient access and patient management
	Physiotherapy	×			
Minor casualty	Main entrance	×			Easy access for patients
	Radiodiagnostics	×			Access to radiodiagnostics, and shared use of support spaces and nursing staff
	Outpatients		×		
	GP ward		×		For convenient provision of out of hours nursing cover
Dining	Kitchen	×			
	Ground floor		×		Access to outdoor space
OT/physio	Main entrance	×			Easy access for day patients/GP referrals
	Outpatients		×		Easy access for outpatients
Clinic services	GP premises			×	Shared use of support spaces, consulting suites & treatment spaces
	Community clinics			×	
Radio-diagnostics	Minor casualty	×			Easy access for patients
	Outpatients		×		
GP premises	Whole hospital			×	Easy access for GPs for day-to-day involvement in community hospitals

× = relevant

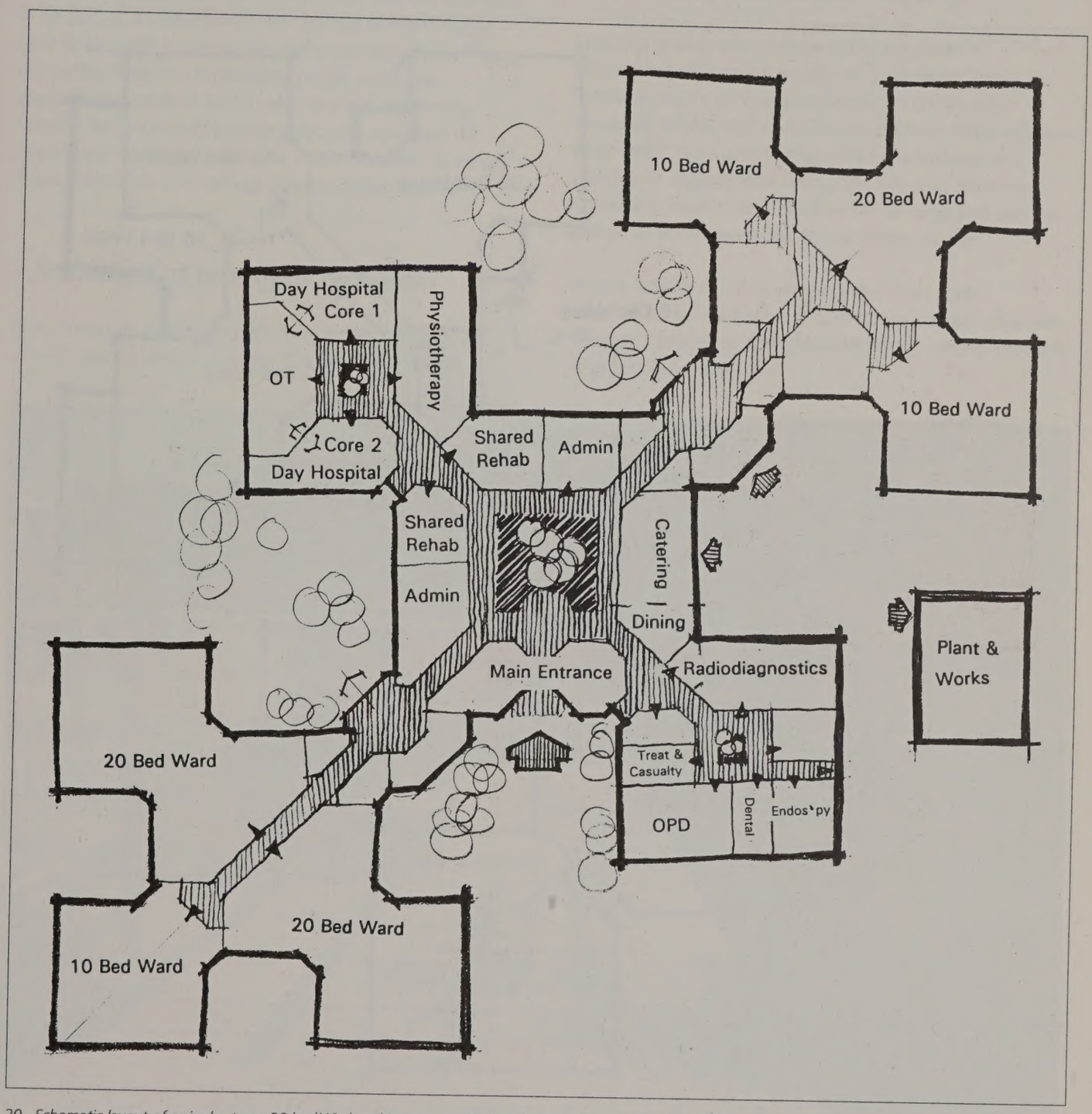


18. Whole hospital relationships. Services for inpatients, day patients and out-patients are clustered in three main zones around a central main entrance/ admin core

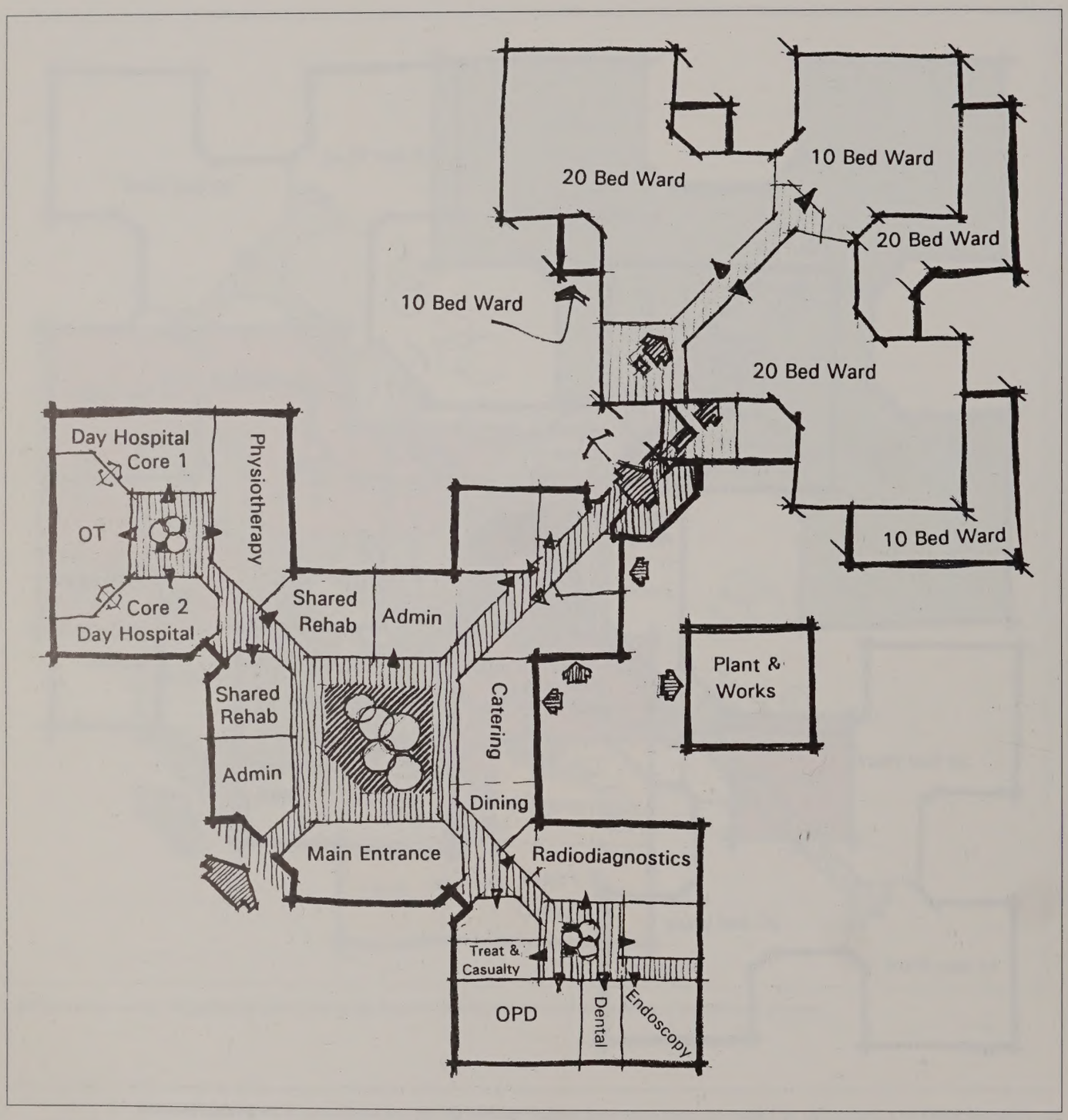
- *Zone 1 contains clinic services (including treatment, and, where provided, dental and endoscopy services), minor casualty and radiodiagnostics. These are primarily for out-patients, although some day and inpatients may use radiodiagnostics, treatment and endoscopy.*
- *Zone 2 contains the day hospital and rehabilitation services. Primarily for day patients, session use may also be made by inpatient and out-patients (e.g. antenatal relaxation in physio exercise area).*
- *Zone 3 contains the main inpatient accommodation.*



19. Schematic layout of a 50 bed/20 day place community hospital showing the size and relationship of the principal elements



20. Schematic layout of a single storey 90 bed/40 day place community hospital showing the size and relationship of the principal elements



21. An alternative schematic layout for a 90 bed/40 day place hospital with the wards arranged on storeys

inpatient areas should be provided at ground floor level. Even in urban locations it may still be possible to provide reasonable access to outdoor space directly from first floor wards, (e.g. Lambeth Community Care Centre).

7.4 Information Technology

For maximum effectiveness, community hospitals will need to be part of an information technology network linked both to local GP surgeries and to the nearest DGH. This will facilitate patient referral/discharge, access to appointment systems and to test results. Community hospital design should provide adequate wireways for transmission cabling, space and power supplies for visual display terminals and storage for associated supplies.

7.5 Design of inpatient facilities

The choice of ward design will have a major impact on whole hospital design strategy. The tendency to use standard acute ward designs, which are intended for other purposes and do not provide an environment which reflects the philosophy and pattern of inpatient care appropriate to community hospitals, should be resisted. Community hospitals provide tremendous scope for innovation in inpatient ward design. (See Chapter 9.1).

7.6 Privacy and confidentiality

Ensuring privacy and confidentiality for patients throughout their stay is important in all health care buildings, but is especially important in community hospitals, where staff and patients are more likely to know each other. This concern may affect the location and position of departments within the site (e.g. avoiding consulting rooms overlooked by car parking) and also the design of accommodation for particular services.

Privacy is likely to be more important than good observation in the design of community hospital inpatient areas, in contrast to acute hospital wards, where the focus is generally on the latter.

22. Gardens – Ystradgynlais Community Hospital

7.7 Role of outdoor space

Courtyards and gardens should be designed, not only to provide a pleasant outlook and view, but also as an amenity for use by staff and patients.

Landscaping should provide safe and easy access for leisure and rehabilitation activities, particularly for elderly patients whose sight and mobility may be impaired. Courtyards can provide access to enclosed outdoor space for elderly patients with dementia to wander in safety. There may be occasional bedfast patients who would benefit from access to the grounds.

Landscaping will generally be planned for easy and cost effective maintenance, but there should also be scope for patients to garden, with suitable provision of raised beds.

Courtyards may also be used as a home for hospital pets (e.g. hamsters, rabbits, guinea pigs, ducks, etc).

7.8 Logistics and communications strategy

In smaller community hospitals (e.g. less than 50 beds), most traffic involving patients, staff, supplies, disposal will take place via departmental circulation space.

In a larger community hospital, greater differentiation between whole hospital communications space and departmental circulation may be necessary to avoid use of of departments by through traffic to other departments. Where a 'hospital street' is deemed necessary, careful design will be essential to avoid creating long corridors which conflict with the intended ethos of a smaller scale, non-clinical environment, as compared to a district general hospital.

Where engineering services are distributed in roof spaces, safe and easy access is required by works staff for operational maintenance purposes.

23. Courtyard – Ilkeston Community Hospital

7.9 Expansion strategy

Some limited scope for expansion should be provided, for example:

- earmarked space in the development control plan (DCP) to add another ward, expand outpatients, etc.
- grossing up projected bed numbers, to produce economically-sized wards, may introduce some initial spare capacity.
- careful juxtaposition of services may allow some ebb and flow and shared use of space between them. This may be difficult to achieve where services are provided in physically separate wings, rather than in a linked development.
- if significant expansion of local services is required, provision of another suitably located community hospital may well be preferable to further expansion of existing facilities.

24. Ward corridor – Ystradgynlais Community Hospital

7.10 Flexible and shared use of space

There is an ethos of cooperation in community hospitals, which is less common in an acute hospital setting. Services in community hospitals have less watertight boundaries and may be more interdependent both in terms of staffing and space use.

Shared and multi-use of space may be perceived more as an opportunity than a threat. It can provide flexibility to cope with changing demands and allow each service access to improved provision of shared treatment, consulting or support facilities.

Many community hospital activities will occur only sporadically and do not require dedicated space.

If the community hospital is to provide a resource for local groups and a base from which voluntary agencies can provide services, flexible use of spaces by different users at different times (including evening and weekend use) will be important, but will need to be properly managed.

There are a number of ways in which space sharing can be applied in community hospitals to achieve overall reductions in area and to achieve functional relationships appropriate to a community hospital. Examples are set out in Diagram 25.

25. Options for increasing space utilisation

Wards

- Share pantry utility, staff facilities between two wards
- Use central equipment store for beds etc
- Day space with option to share between two wards

Day Hospital

- Share reception, records, waiting, wheelchair bay with main entrance (where adjacent) and/or out-patients
- Share space with rehabilitation (provided dining tables and easy chairs do not have to be cleared away for rehabilitation activities)
- Share some day space, quiet space, utilities with ward (if adjacent)

Outpatients

- Share reception, records, main wait, wheelchair bay with main entrance and/or day hospital
- Some utilities, treatment and patient facilities can be shared with casualty/day hospital (if adjacent) and community clinics (if present)
- Use of consulting room for counselling and screening activities

Radiodiagnostics

- Share reception and filing with main entrance/out-patients
- Share processing with dental (if adjacent and if systems are compatible)

Minor casualty

- Share reception, records, etc, with out-patients and/or main entrance
- Share utilities, patient facilities with out-patients (if adjacent)

Rehabilitation

- Physiotherapy and OT can share offices, open exercise area and storage areas
- Physiotherapy and OT can share reception, records and possibly wheelchair bay with main entrance
- Physiotherapy and OT can be combined with day hospital and share utilities and patients facilities with day hospital
- Use of physiotherapy exercise area for health education activities

Staff facilities

- Shared provision of changing, rest, catering and seminar facilities

7.11 Interior design

Interior design can make a major contribution to the achievement of an appropriate quality of environment for a community hospital.

Issues are:

- **Use of carpeting:** in main corridors, ward corridors, bed areas and day rooms. Advantages are reduction in noise levels and injuries to elderly patients. Careful choice plus a well-managed cleaning policy can keep carpets stain and odour-free.

- **Choice of furniture:** should enhance rather than detract from overall appearance. Function should be balanced carefully against aesthetics.

- **Soft furnishings:** use of duvets, coordinated curtains and bed linen can all contribute to creation of a more domestic environment, especially in inpatient and day hospital areas.

- **Colour and pattern:** can be used to effect to differentiate one department from another, to differentiate bed bays from each other and aid patient orientation within wards.

- **Lighting:** thoughtful coordination of artificial lighting with other aspects of the interior decor can greatly assist the creation of a non clinical environment. This particularly applies to entrance, receptiion, circulation, dining and sitting areas, where the introduction of decorative lighting may be appropriate. However, it is essential to ensure that any decorative lighting does not degrade the clinical quality colour rendering of the lighting provided in clinical areas. A combination of direct and indirect techniques can be used to achieve variety.

- **Art:** creative use of art in all its forms can be used to "humanising effect". Colour, pattern, texture, paintings, textiles, sculpture, photographs, etc. can provide visual relief in corridors, interest in dayrooms, waiting areas and courtyards and important links with the local community.

26. Day hospital courtyard – Lambeth Community Care Centre

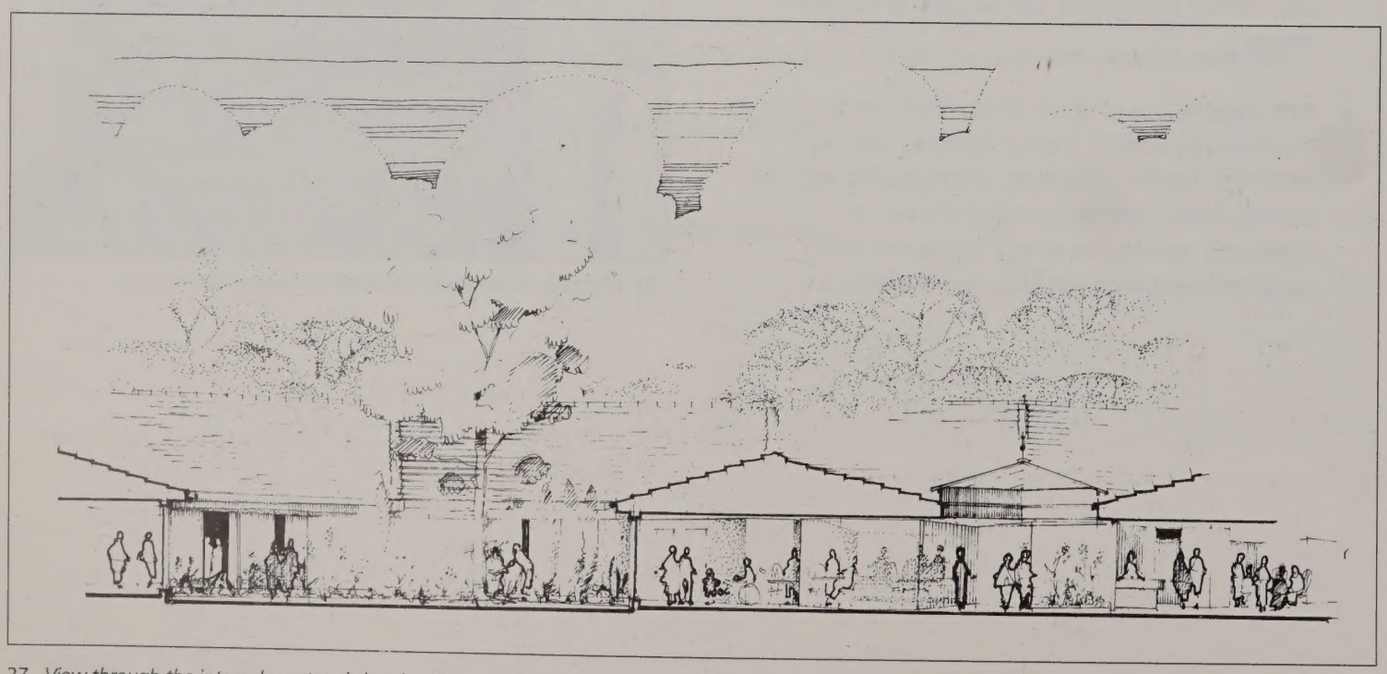
8.0 Whole hospital operational policies with implications for design and space utilisation

Operational policies will influence the way that community hospital services are provided and managed.

At a whole hospital level the following are operational policy issues which have implications for design, space provision and utilisation:

- **Bed management:** by whom (e.g. consultants, GPs or nurses) and on what basis?
- **Patient management:** who has overall responsibility and day-to-day responsibility? Clear admission and discharge policies and associated review mechanisms will be essential to maintain the community hospital ethos and avoid blocking of beds.
- **Mixing or separate provision of services and facilities for elderly and EMI patients:** clarification of what is regarded as good practice.
- **Shared and multi-use of space:** evening and weekend use by local groups, voluntary organizations, social services etc. This will need to be planned positively if it is to be successful.
- **Catering policy:** cook chill policy will have implications for design of kitchens, wards and day hospitals.
- **Storage policy:** provision of hospital level store or departmental storage only.
- **Waste disposal policy:** arrangements will be required for collecting, temporary holding and disposal of clinical and domestic waste, given that the hospital is unlikely to have an on-site incinerator.
- **Staff changing:** provision of central changing area, or local changing for some services.
- **Patients' laundry:** provision of personalised patients laundry service will have spatial implications, if it is to be provided on site.
- **Security:** arrangements will need to be made to provide adequate security for staff and patients particularly where a 24-hour minor casualty service is provided.
- **Education and training policies:** programmes and space for in-service education and training will be required for all types of staff.

Laundry, pathology, pharmacy, and sterile supplies will be provided by the DGH or other off site district services. Detailed guidance on other whole hospital operational policies and on policies and procedures for individual community hospital services can be found in 'Towards Good Practices in Small Hospitals – Some Suggested Guidelines' (NAHA 1988).



27. View through the internal courtyard showing the staff dining area

9.0 Planning accommodation for community hospital services

This Chapter focuses on planning and design issues associated with individual community hospital services. For each service, material is presented under the following headings:

- scope
- sizing
- other relevant guidance
- operational policies
- planning issues and options
- relationship to other services
- total quality management
- interior design
- multi use of space.

The bubble diagrams which appear throughout Chapter 9 are intended to illustrate **possible** relative locations of spaces and/or activities. They do **not** necessarily indicate ownership of spaces as some spaces may be shared between two or more services. Plans are included for illustration purposes only.

Reference is made to other relevant guidance material but this guidance is not repeated here. A complete list of other relevant Health Building Notes is provided in Appendix 5.

9.1 Inpatient accommodation

9.1.1 Scope

Inpatient wards in community hospitals may accommodate acute and pre-convalescent patients, patients requiring respite care, rehabilitation and terminal care. Some community hospitals may provide GP maternity beds for selected low risk consultant screened patients, or for use by postnatal patients discharged from the DGH. Respite care may also be provided for younger disabled patients. All these patients will generally be under the care of their GPs. Other specialties may include elderly, EMI, and acute mental illness patients. For elderly and EMI patients, the focus will generally be on rehabilitation and respite care rather than on continuing care. These patients may be under the care of a consultant, although GPs will take day to day responsibility. Nurse managed beds, for those patients requiring primarily nursing care and rehabilitation, may also be a feature of community hospitals.

9.2.1 Sizing

Estimates of numbers of beds required should be carefully co-ordinated with the provision of beds in the DGH and other local hospitals, so that community hospital beds are an integral part of a continuum of care for patients and are not seen as an optional extra. Careful assessment should be made of the extent of local support, GP commitment to, and likely use of community hospital beds.

9.1.3 Other relevant guidance

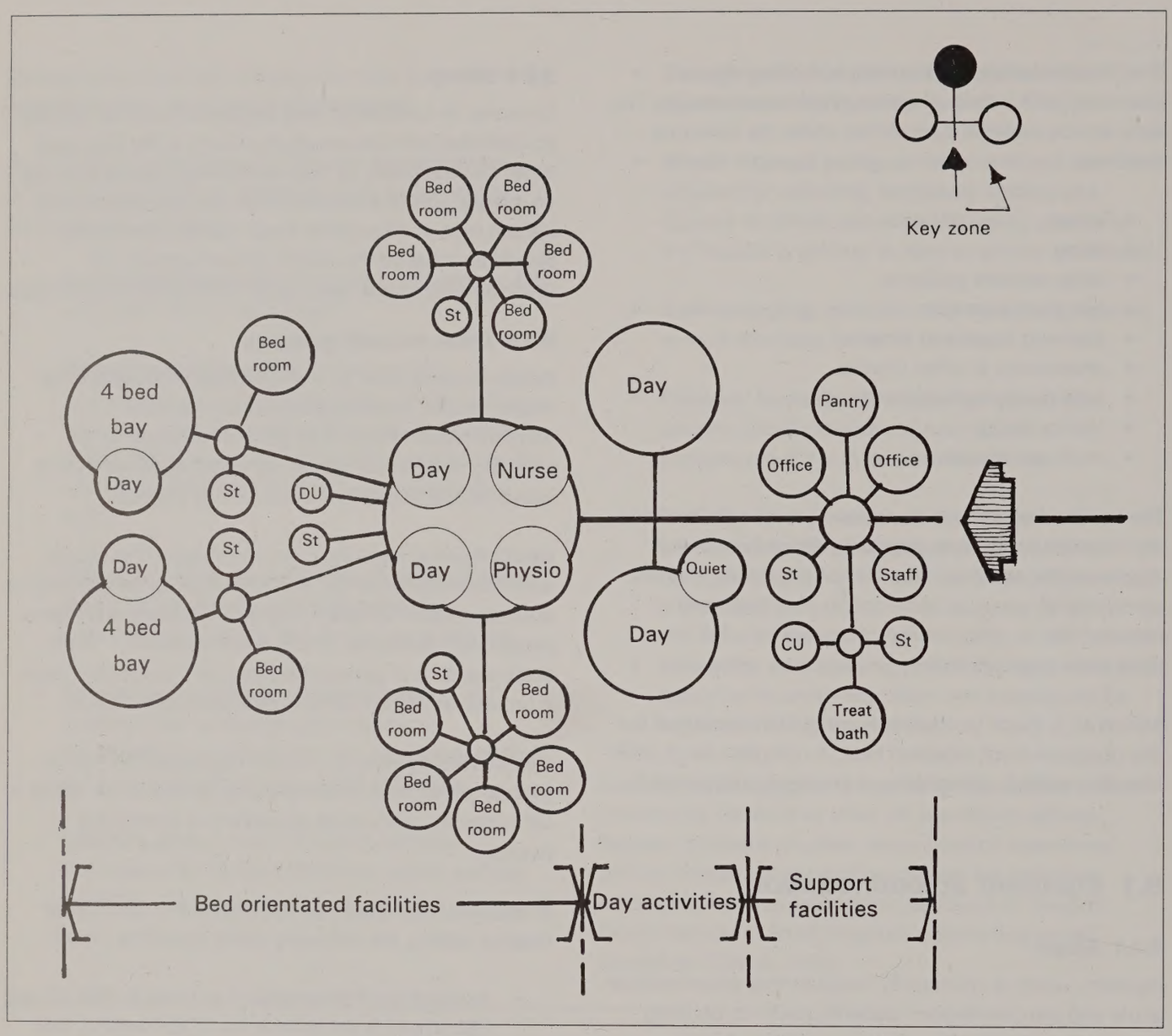
Health Building Note 37 – 'Hospital accommodation for elderly people' provides guidance on inpatient accommodation which is of general relevance to the planning of GP acute wards, nurse managed wards and wards for the elderly in the community hospitals.

Health Building Note 35 – 'Accommodation for people with acute mental illness' is of relevance to the planning of accommodation for elderly mentally ill people and elderly people with dementia. Health Building Note 4 – 'Adult acute wards' is of general background interest only, since it focuses on the care of acutely ill patients in a DGH.

Health Building Note 21 – 'Maternity department' is of general relevance in those relatively few instances where a GP maternity unit is to be provided in a community hospital.

In applying these guidance documents in a community hospital setting, the following points should be noted:

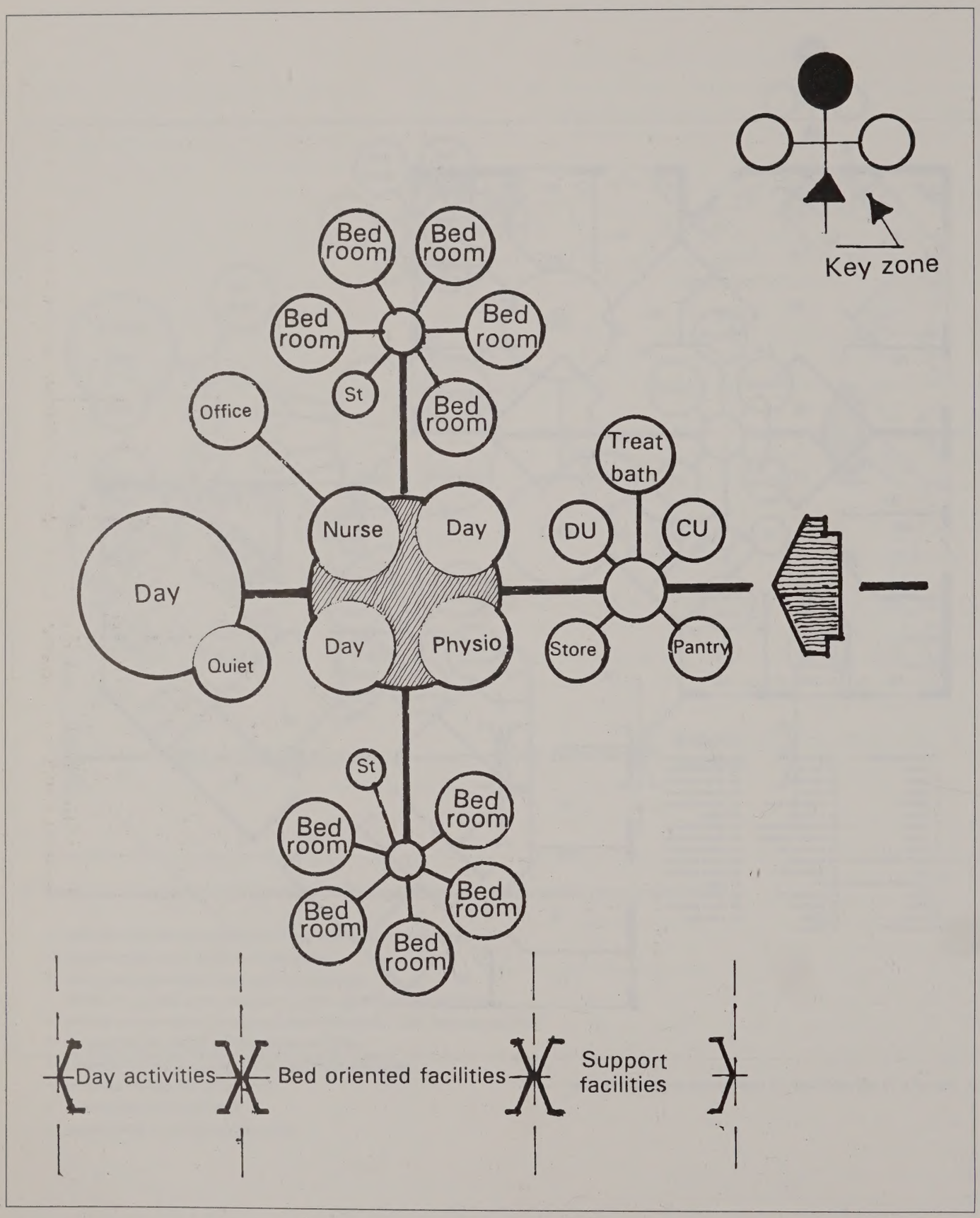
- standard ward designs (such as those in HBN 37 and HBN 4) which are suitable for a DGH setting, may be appropriate for the types of patients to be cared for in a community hospital. The opportunity to develop innovative ward designs based on more informal arrangements of single rooms and bed bays with smaller numbers of beds, should not be missed.
- bed spaces may need to be larger than DGH bed spaces to accommodate armchairs, wheelchairs, larger wardrobes for personal clothes, etc.
- privacy, rather than observation, may be the more dominant factor in the planning of community hospital inpatient areas.



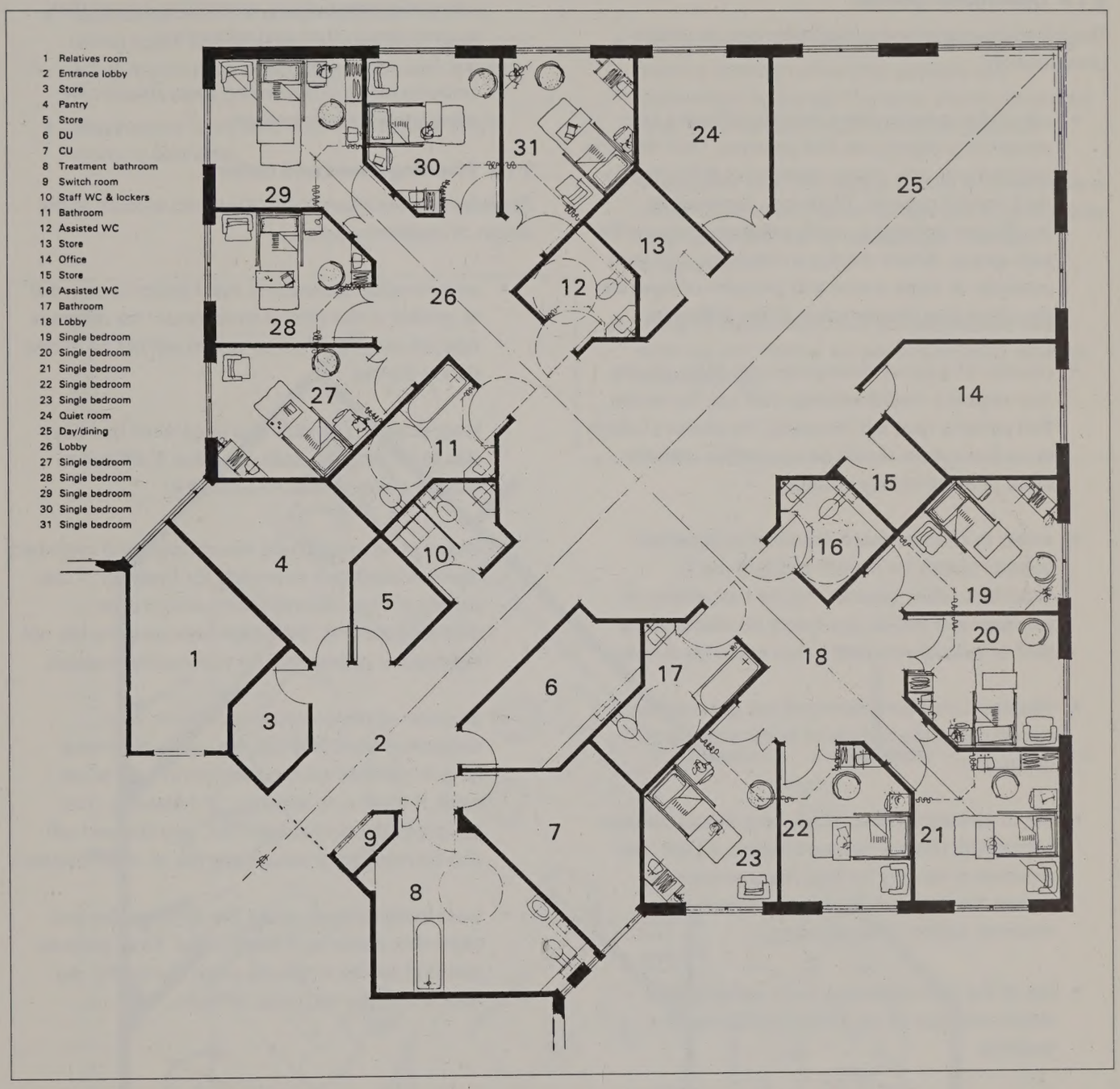
28. 20 Bed ward showing zoning into bed related facilities, day facilities and support facilities. Points to note include:

- *small day areas for 2/3 people within bed bays and off circulation areas*
- *physiotherapy 'areas' within main circulation*
- *appropriate supervision of both bed and day areas*
- *flexibility to provide accommodation in either single rooms or 4 bed bays*
- *sanitary accommodation strategically located to service both bed and day areas*
- *the possibility of ensuite sanitary accommodation*
- *separation of clinical functions from patient oriented areas*
- *accessible storage and utility spaces*
- *choice of day and quiet areas*
- *potential links to gardens and/or patios*

29. Plan of a 20 bed ward with 12 single rooms and two 4 bed bays



30. 10 Bed ward. As with 20 bed ward, this arrangement is zoned into bed, day and support areas; the latter being located near the ward entrance to allow possible sharing with another 10 bed ward



31. Plan of a 10 bed ward, all beds in single bed rooms

Aspects of existing guidance which should be stressed include:

- maximum distances (12m) from bed areas to WCs (HBN 37), to maintain patient independence
- inappropriateness of acute ward type staff base for EMI wards

9.1.4 Operational policies

The following operational policy issues require careful consideration:

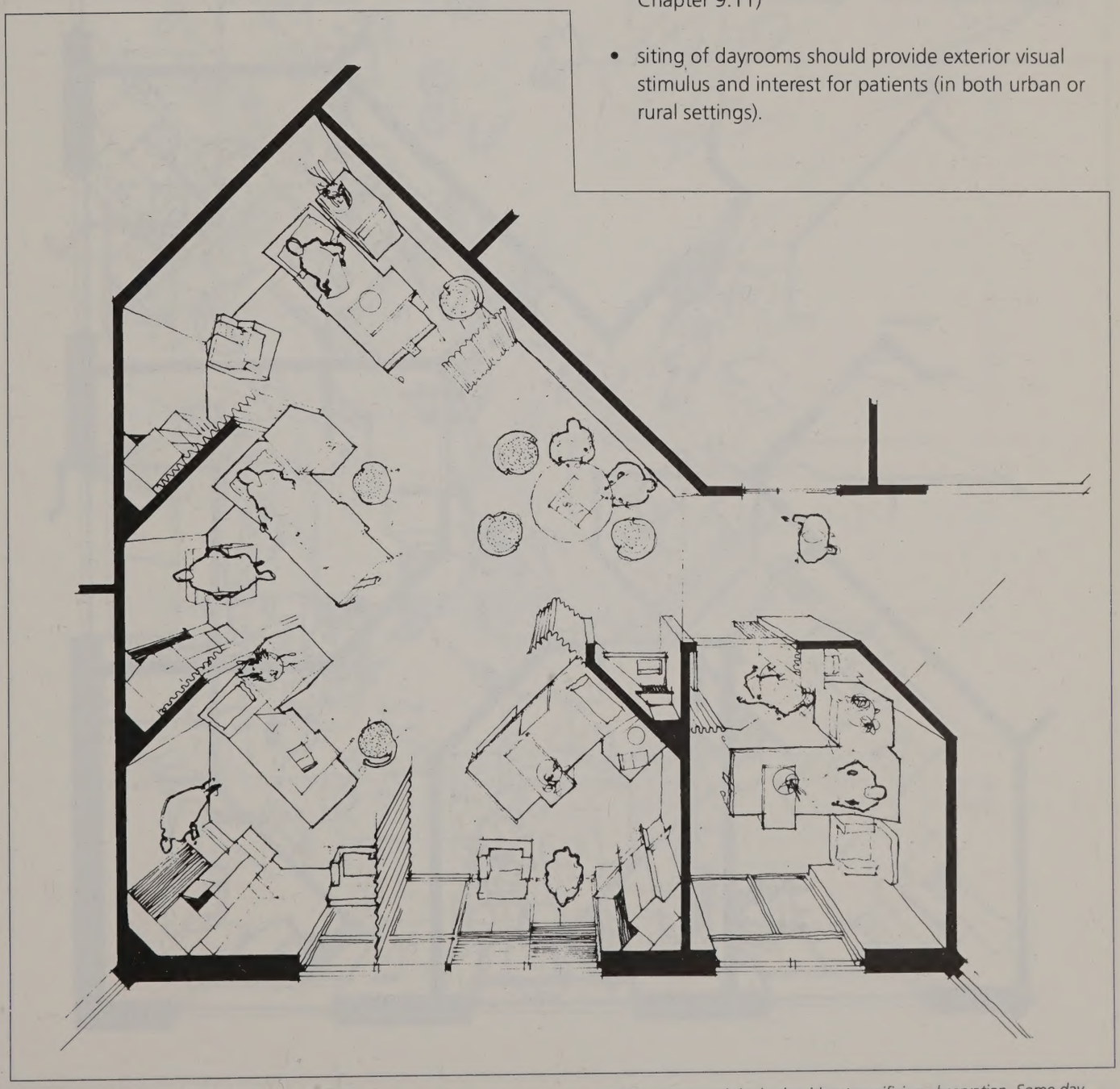
- use of the same inpatient ward by different care groups (e.g. elderly and EMI patients). Their differing requirements may create operational difficulties for staff and for patients. There may, however, be insufficient demand to justify separate provision for each group. Where sharing is necessary, increased provision of single rooms and provision of separate day space may obviate some of the difficulties.
- creation of a secure environment for EMI patients may require a means whereby staff can be alerted that patients have left the ward. The choice of alarm or control system should be compatible with the ethos of a community hospital.
- access to outdoor space. Provision of attractive outdoor spaces for patient and staff use is important. Many patients may be frail, elderly or confused and will be dependent on assistance by staff or voluntary helpers if they are to go outside.
- treatment. Inpatient treatment will generally be carried out at the bedside or in the treatment bathroom.
- use of sanitary facilities. Policy here should strike an appropriate balance between safety and risk. The provision of sanitary facilities and operational policies for their use should work together to maximise patient independence.
- use of the TV in day areas. Local policy should ensure provision of choice and avoidance of nuisance.
- involvement by relatives in the care of patients. This may have implications for provision of support accommodation in wards, for use by relatives.
- storage policy. If a hospital store is not provided, adequate storage will be required at ward level for disposables and other bulk supplies.
- suitable choice of carpeting plus a well managed carpet cleaning policy is essential to ensure that carpets remain stain and odour free.
- smoking policy in day/dining areas should cater adequately for non-smokers.

9.1.5 Planning issues and options

The following are issues to be taken into account in the design of inpatient wards:

- an innovative approach to ward design is essential to provide a non-clinical environment for different types of patients, most of whom will not be in bed during the day.
- long, straight, corridors and large multi bed bays should be avoided. Both will make it difficult to achieve a non-clinical environment.
- choice of an appropriate mix of single and multi-bed rooms is important to provide for flexibility in use, patient privacy, observation of acutely ill or disturbed patients. Eight bed bays are generally not regarded as appropriate for community hospitals.
- provision of designated single rooms, or a designated multi-bed bay, for use by post-natal lying-in patients will be essential on a GP acute ward, if there is no separate GP Maternity Unit. Ensuite bathroom facilities (WC and shower) will also be required to reduce any risk of cross infection.
- ward design should reflect the different day and night-time patterns of ward usage. Most patients and staff will be in the day areas during the day time and in the bed areas at night.

- location of day spaces within easy access from bed areas is desirable both for patient convenience and efficient ward management.
- consideration should be given to the installation of an induction loop in the dayroom so that patients with hearing aids can hear the TV at normal volume and without disruption to other patients and activities.
- separate provision of adequately sized day and dining space and provision of a separate quiet room, will give patients a choice of location and activity.
- direct access to outdoor space from some single rooms is desirable.
- suitable furniture will be required on which to stand TVs in single rooms, or multi-bed bays.
- WCs should be within easy reach (12m) of day spaces and bed spaces.
- adequate provision of washing facilities should prevent inappropriate use by patients of clinical hand wash facilities in multi-bed rooms.
- design of bed areas should reflect an appropriate balance between privacy for patients and observation by nurses. The latter may be important only for a relatively small number of patients.
- adequately sized bed spaces should accommodate a patient's personal clothes storage and a comfortable chair or wheelchair by the bedside. (See also Chapter 9.11)
- siting of dayrooms should provide exterior visual stimulus and interest for patients (in both urban or rural settings).



32. View of 4 bed bay adjacent single room, showing the possibility of achieving 'private' areas around the beds without sacrificing observation. Some day space is provided within the bay for patients and relatives

- preservation of privacy and dignity for patients is essential, particularly in the provision of sanitary accommodation. WCs should not open directly onto spaces in which people may gather (e.g. dayrooms or social spaces).

- adequate provision should be made at ward level for OT and physiotherapy. Circulation space can be used for walking bars, steps, etc.

For EMI patients, the following are also important issues:

- single rooms are preferable to multi bed bays to preserve patient privacy and dignity and minimise noise and disruption to other patients.

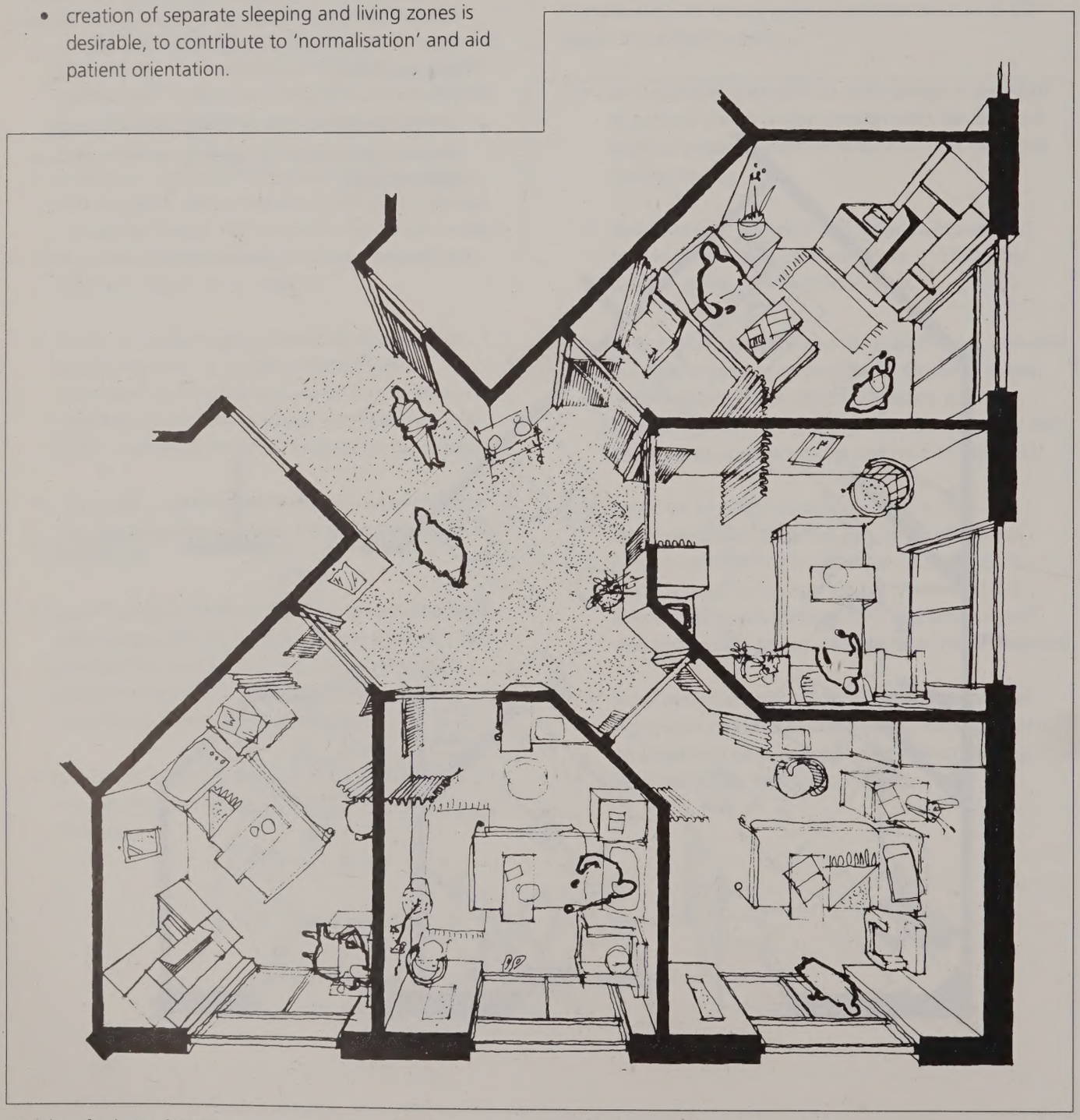
- creation of separate sleeping and living zones is desirable, to contribute to 'normalisation' and aid patient orientation.

- an informal 'gathering' area or 'forum' for patients within the ward, perhaps as part of the circulation space should be considered.

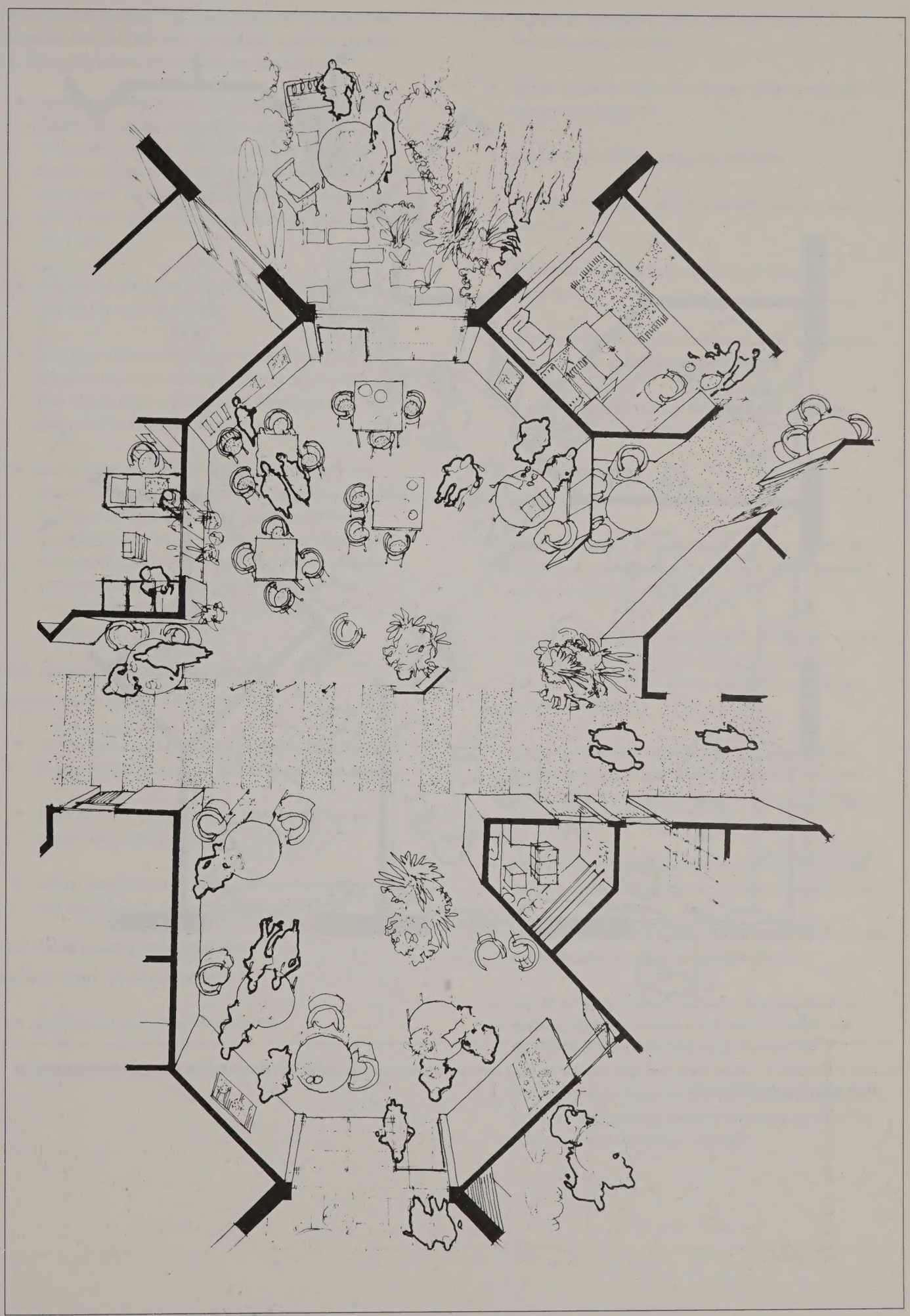
- access to a safe outdoor area is important, so that patients can wander without getting lost.

- if the ward is shared with elderly patients, a separate day and dining space should be provided, for use by EMI patients.

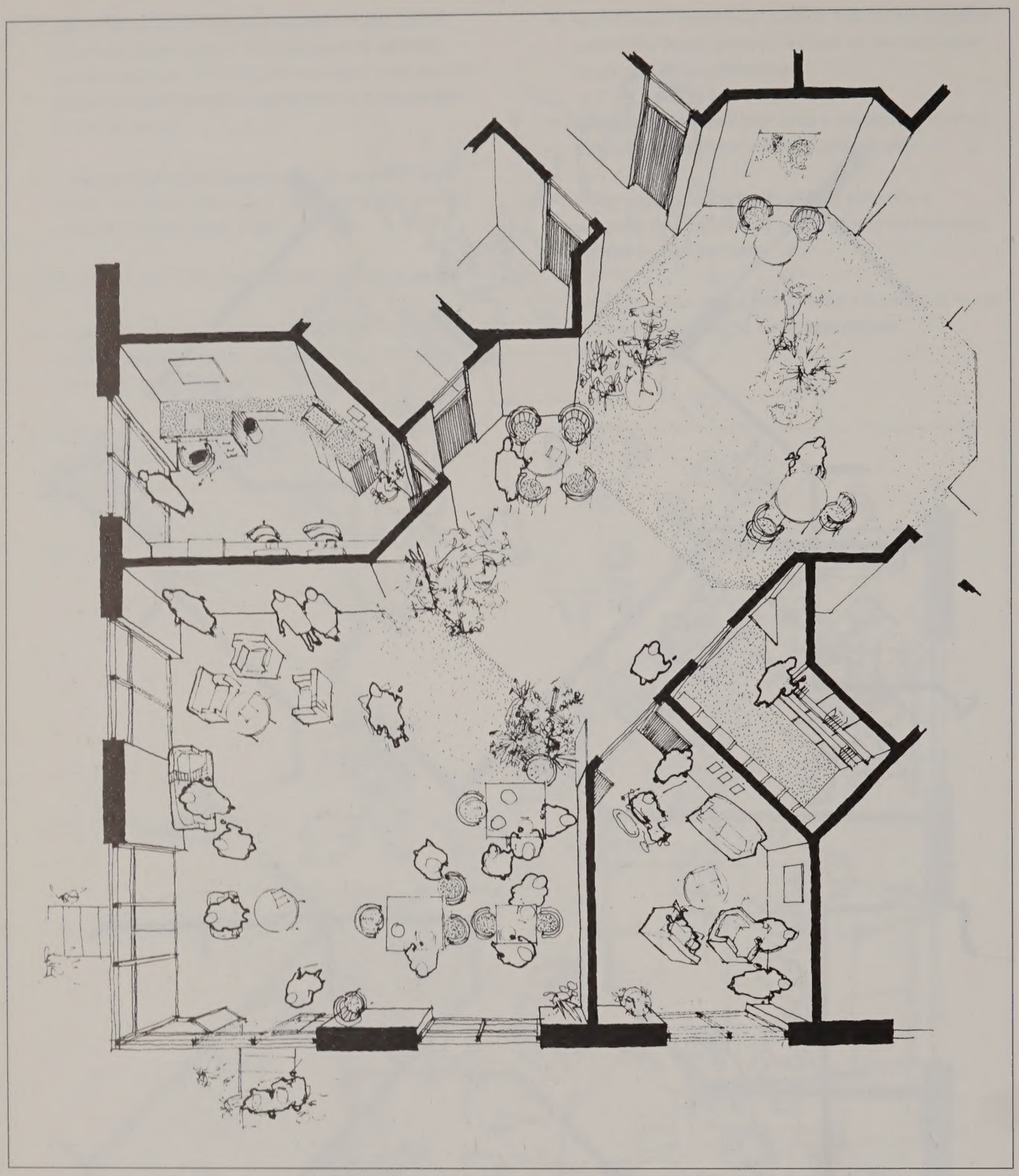
- provision of an office rather than a traditional nurse base will generally be more appropriate.



33. View of a cluster of 5 single rooms. This arrangement allows greater privacy and dignity for the patient without sacrificing observation. The space required is identical to the 5 beds in figure 32



34. View of the day space in a 20 bed ward, showing separation into spaces of a more domestic scale including a separate quiet room. Note the access to outdoor spaces



35. View of day space in a 10 bed ward. Note again the separate quiet room and access to outdoor spaces. The 'nurses base' is seen as an informal table and chairs adjacent to the office space

Where a local decision has been made to provide a GP Maternity Unit for low risk consultant screened patients, the following issues should also be considered:

- facilities should be seized appropriately to local needs, taking account of the availability of DGH maternity facilities. Ten beds and two normal delivery rooms are likely to be the minimal viable size of unit. Additional beds may be required if the unit is also to take post natal lying in patients from the DGH.
- the mix of single and multi-bed rooms will be a matter for local decision.
- provision of ensuite bathroom facilities (WC and shower) for each multi-bed bay or shared between two single rooms is desirable. Provision of a bath for pain relief should be considered.
- ward designs in which the ward is divided into discrete modules of four or five beds may facilitate shared used of a 20–24 bed ward by different groups of patients. However, where shared use is envisaged, it will be essential to provide ensuite bathroom facilities (WC and shower) for the maternity beds, in order to reduce any risk of cross infection.

9.1.6 Relationship to other services

Inpatient wards should be located:

- on the ground floor, where possible, (especially for EMI patients) to provide access to outdoor space
- close to the main entrance, for easy access by visitors and elderly relatives
- within reasonable proximity to hairdressing and to the day hospital, physiotherapy and OT.

9.1.7 Total quality management

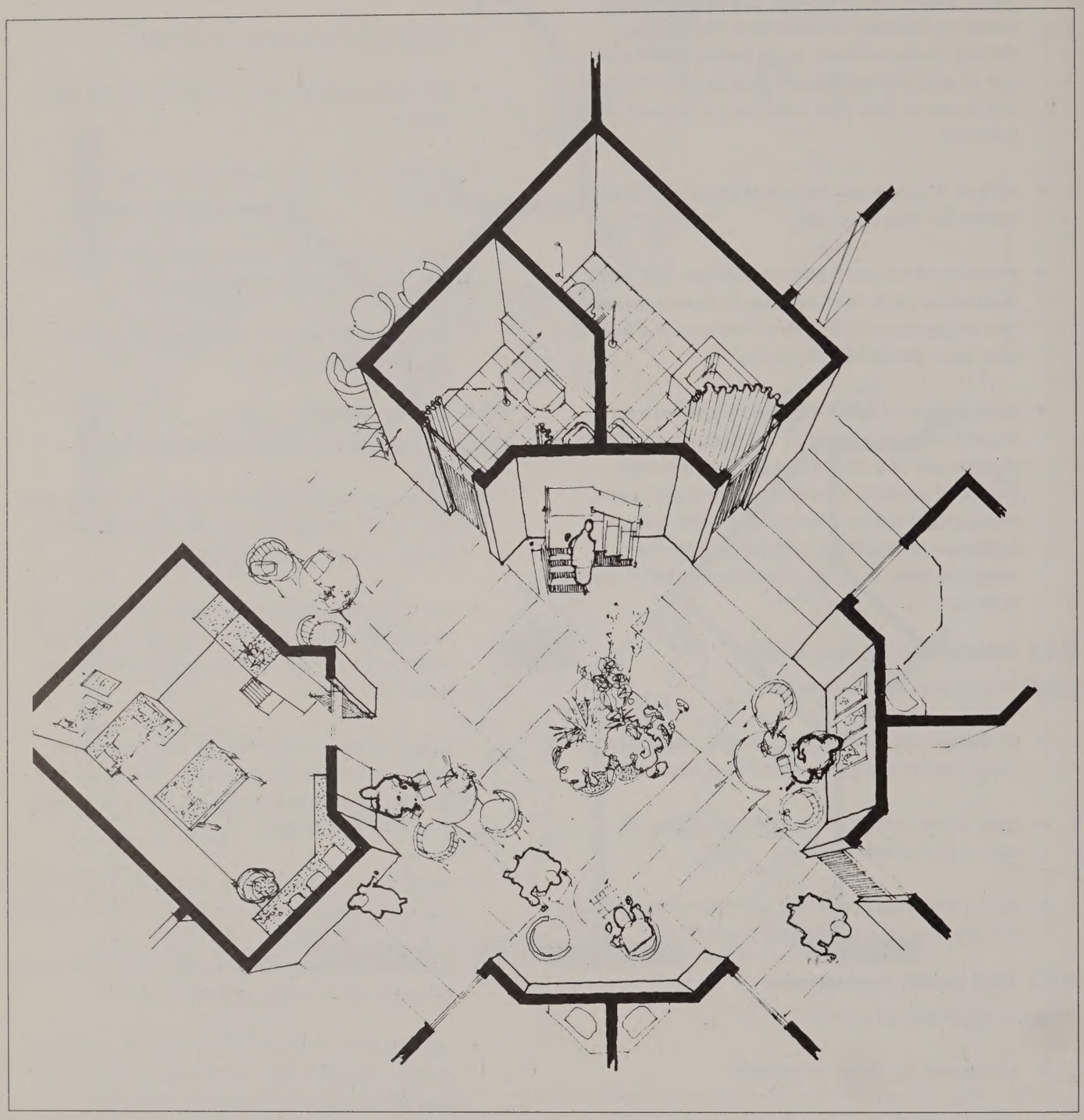
Inpatient wards should provide:

- a choice of day areas for patients
- privacy in bed areas and sanitary facilities
- access to recreation, entertainment and rehabilitation activities
- scope for personalisation of bed areas (especially for longer stay patients)
- access to outdoor space and activities
- an exterior outlook which provides interest and stimulus
- scope for relatives to participate in the care of patients
- accommodation for husband and wife admissions, especially on wards for elderly people
- a child centred environment for areas used by younger disabled patients.

9.1.8 Interior design

Issues here include:

- use of carpeting in ward corridors, day rooms and bed areas, can create a non-clinical environment, reduce accidents, noise levels, etc
- use of duvets, patterned curtains, wallpaper in bed areas in different colours and patterns, can also contribute to a non-clinical environment and aid patient orientation
- choice of dayroom and dining furniture should reflect an appropriate balance between function and aesthetics. Use of sofas as well as arm chairs should be encouraged
- lighting. Use of table lamps and other decorative lighting in day areas, can create an informal setting.
- provision of display space, in bed spaces, for photos, cards etc allows scope for personalisation.
- use of art (e.g. murals, picture, photos, sculpture, textiles, etc) can enhance the ward interior and provide linkages with the local community.
- the design and furnishing of multi-bed bays should strike an appropriate balance between privacy for patients and observation by staff.



36. View of the central area to the bed cluster in a 20 bed ward. The nurse base is an informal table adjacent to the office. Note the provision of seats for patients and relatives and the integration of physiotherapy aids into the general circulation space

9.2 Day hospital services

9.2.1 Scope

Day hospitals provide medical and nursing care, social support and access to physiotherapy, occupational therapy, speech therapy, chiropody services, etc. for a range of care groups (e.g. elderly, elderly mentally ill (EMI), acute mentally ill (AMI), younger physically disabled and terminally-ill patients).

The scope and type of services to be provided should be clearly defined. Some daycare may be provided by, or jointly with, other agencies, e.g. Macmillan, local authority social services, etc.

9.2.2 Sizing

Estimation of day hospital places should be based on a careful assessment of the local population's health needs, taking into account the availability of other daycare facilities and the referral preferences of local GPs.

Demand may be difficult to assess, but a reasonable attempt is necessary to avoid the provision of oversized and underused facilities, or facilities which are never opened, because of lack of demand.

9.2.3 Other relevant guidance

Health Building Note (HBN) 37 – 'Hospital accommodation for elderly people' Chapter 3, Day hospitals, is generally applicable to community hospitals, except that:

- the OT, physiotherapy guidance and space standards in HBN 37 will not be appropriate for a community hospital, where rehabilitation services cater for the whole hospital and for direct GP referrals and should be planned accordingly

- day hospitals for elderly people in community hospitals may be smaller than HBN 37 day hospital sizes (25–40 places), providing as few as 15 places. Guidance on smaller day hospitals for elderly mentally ill people is available in Health Building Note 35 – 'Accommodation for people with acute Mental Illness'.

Particular note should be taken of the maximum travel distance (12m) to WCs and of the avoidance of open plan day and dining areas, as recommended in HBN 37. These aspects have been ignored in some recent community hospital designs.

9.2.4 Operational policies

The following operational policy issues require careful consideration:

- use of a day hospital by different care groups (e.g. elderly and EMI), either on different days or at the same time

- use of the day hospital by inpatients and provision of direct access for inpatients to specific services (e.g. hairdressing)

- use of TV in the day area. Provision of choice and avoidance of nuisance is important.

9.2.5 Planning issues and options

The following are issues to be taken into account in the design of day hospital accommodation:

- scope for shared use of treatment spaces, activity spaces and WCs, with physiotherapy and OT should be explored.

- a close relationship between the day hospital wards for elderly and EMI patients may provide scope for shared use of nursing staff.

- provision of separate rather than combined day and dining areas is desirable.

- shared provision of day and dining space for rehabilitation activities may create operational difficulties.

- consideration should be given to the installation of an induction loop in the dayroom so that patients with hearing aids can hear the TV at normal volume and without disruption to other patients and activities.

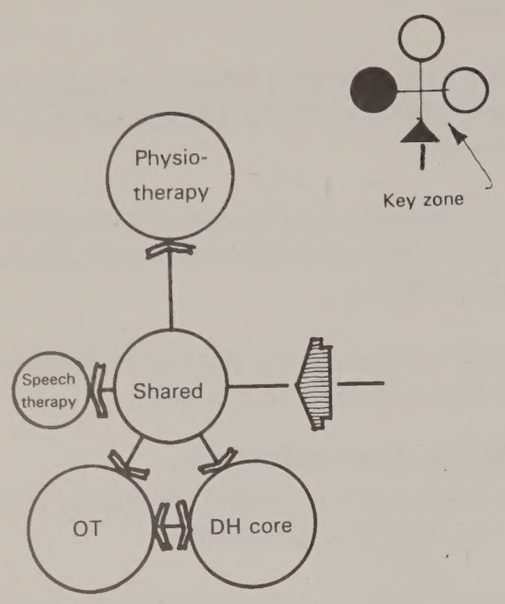
9.2.6 Relationship to other services

The day hospital should be located:

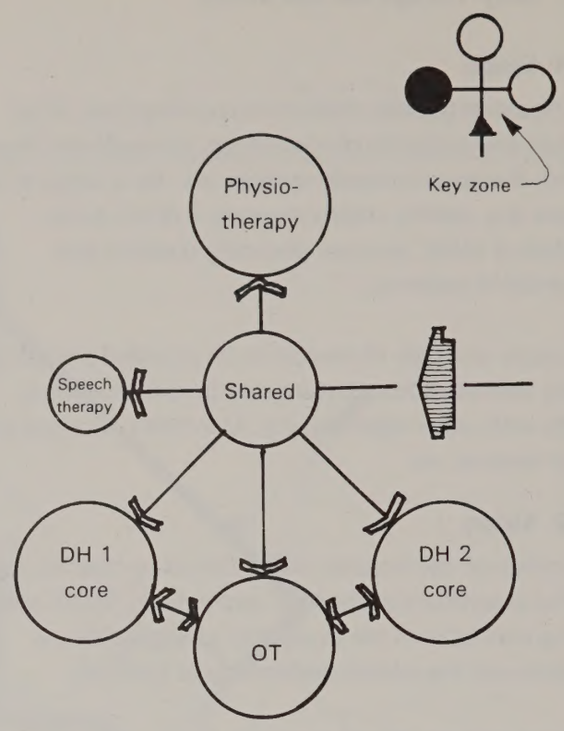
- on the ground floor, with easy access from the main entrance.

- in close proximity to OT and physiotherapy.

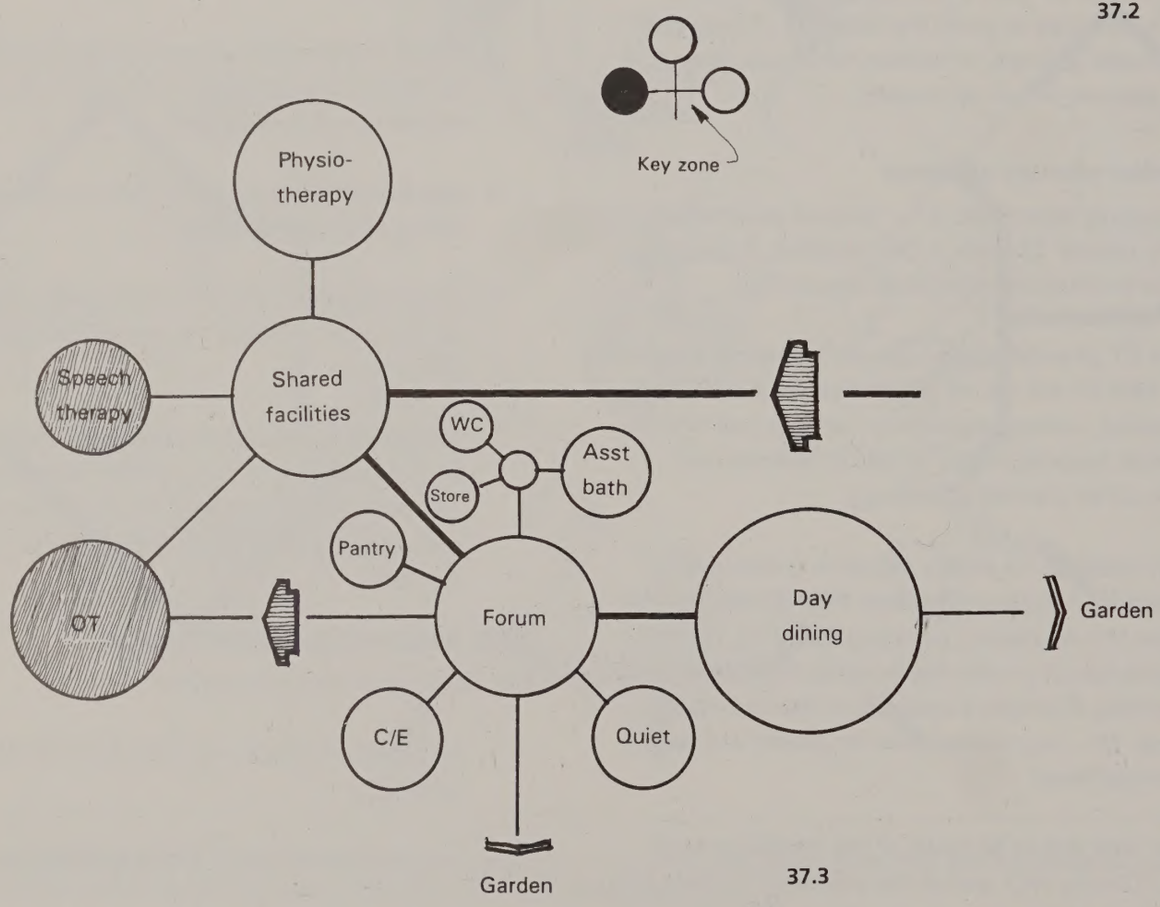
- to provide direct access (not via the day hospital) to hairdressing, chapel, etc. which may be used primarily by inpatients, or during evenings and weekends.



37.1



37.2

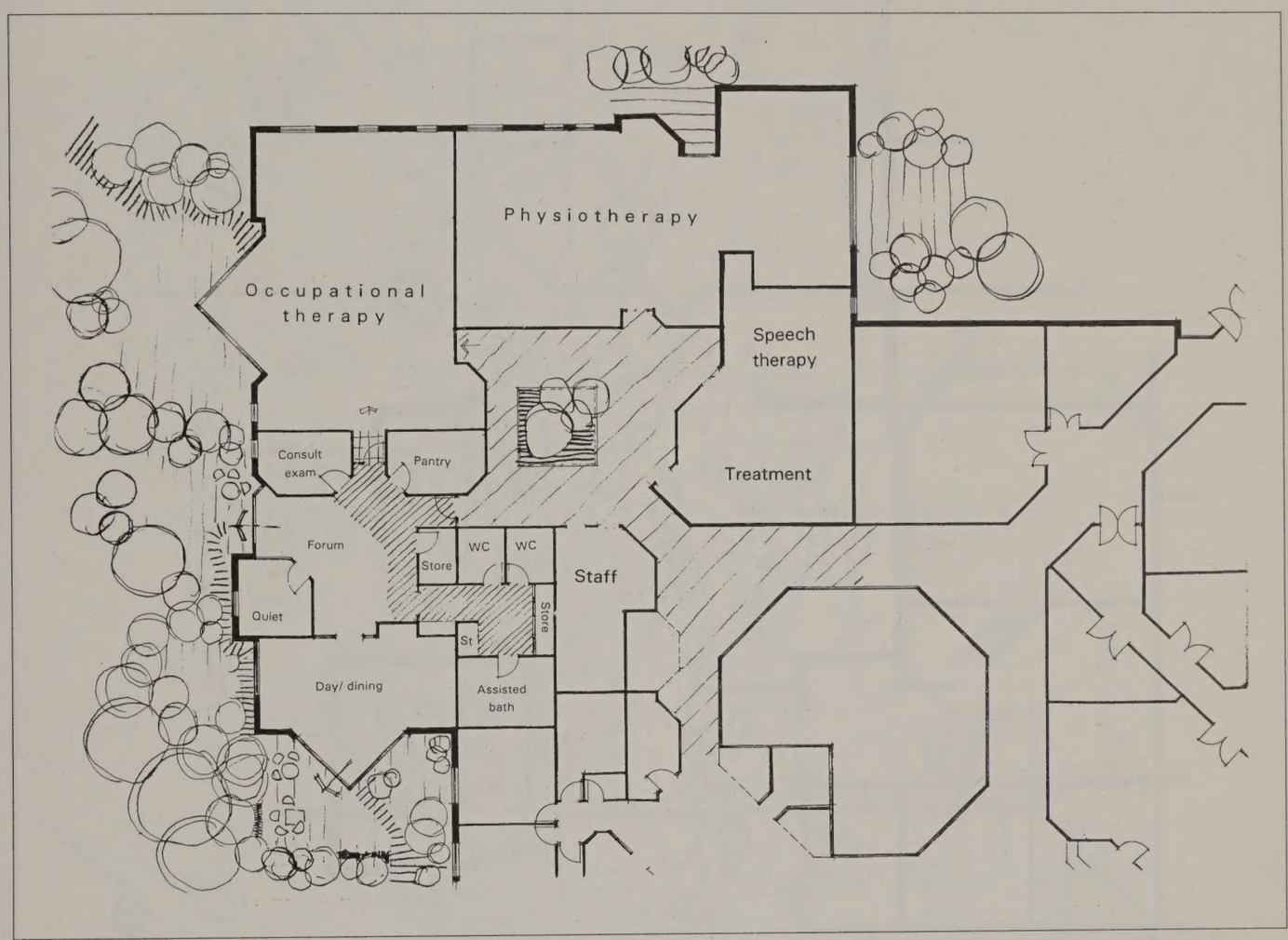


37.3

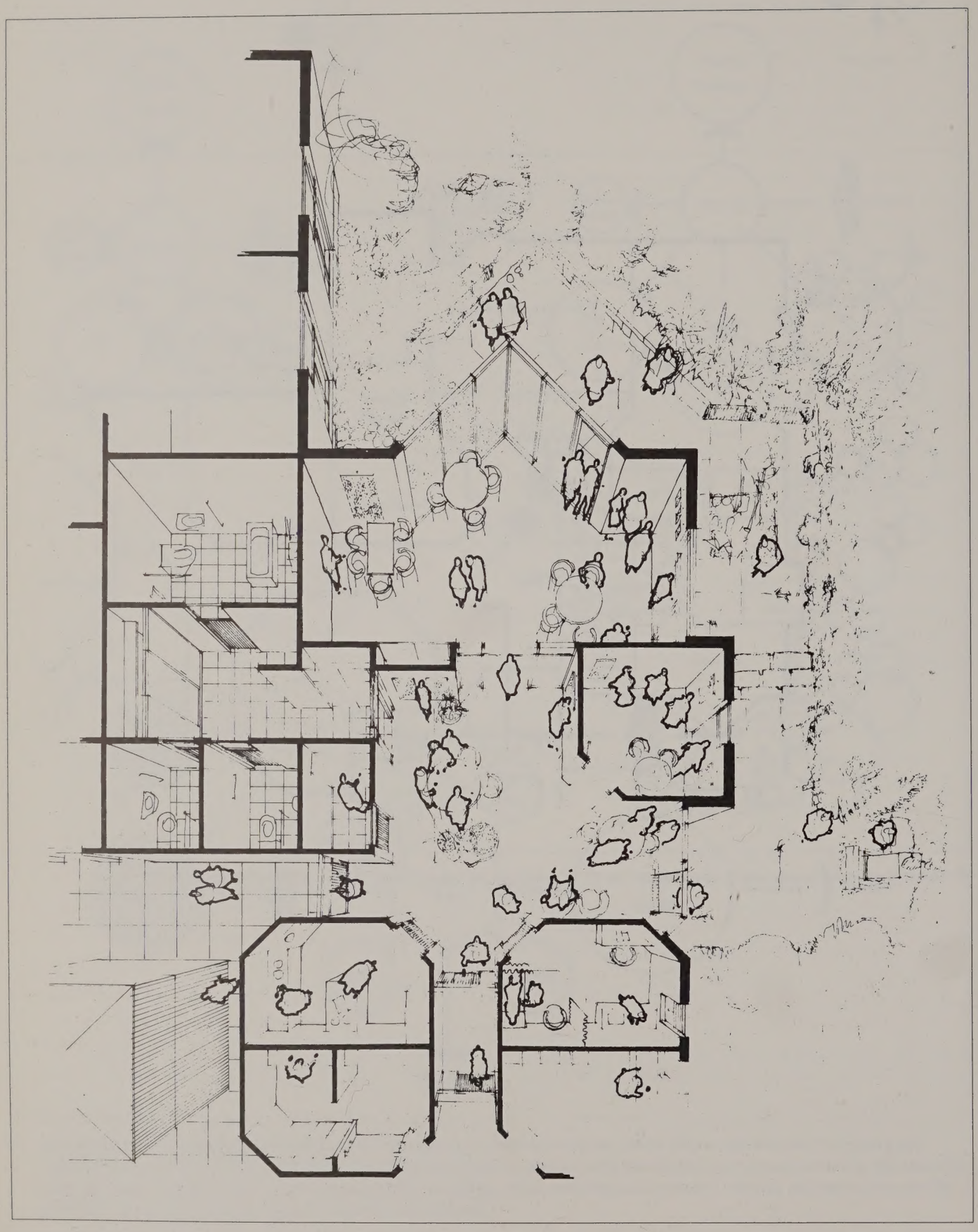
37.1 Rehabilitation and day hospital. This arrangement shows the possibility of combining a core day hospital function with joint use of OT, physio- and speech therapy to provide a full day hospital facility. This concept also allows sessional use of the latter facilities when not required for the day hospital. In a small unit of up to 20 places, one core day hospital will suffice. In addition, certain shared functions (treatment, chiropody and hairdressing) could be provided in a central zone equally accessible to out-patients and inpatients

37.2 Rehabilitation and day hospital (larger unit). If the scheme is to provide 40 day places this might be provided by 2 core day hospitals sharing access to OT, physio- and speech therapy

37.3 Day hospital core. The core day hospital comprises a central 'forum', day, dining and quiet rooms, together with a C/E room and WC/bath facilities. Potential access to outdoor space is important, as is access to OT, physio, speech therapy and other shared facilities (e.g. chiropody and hairdressing)

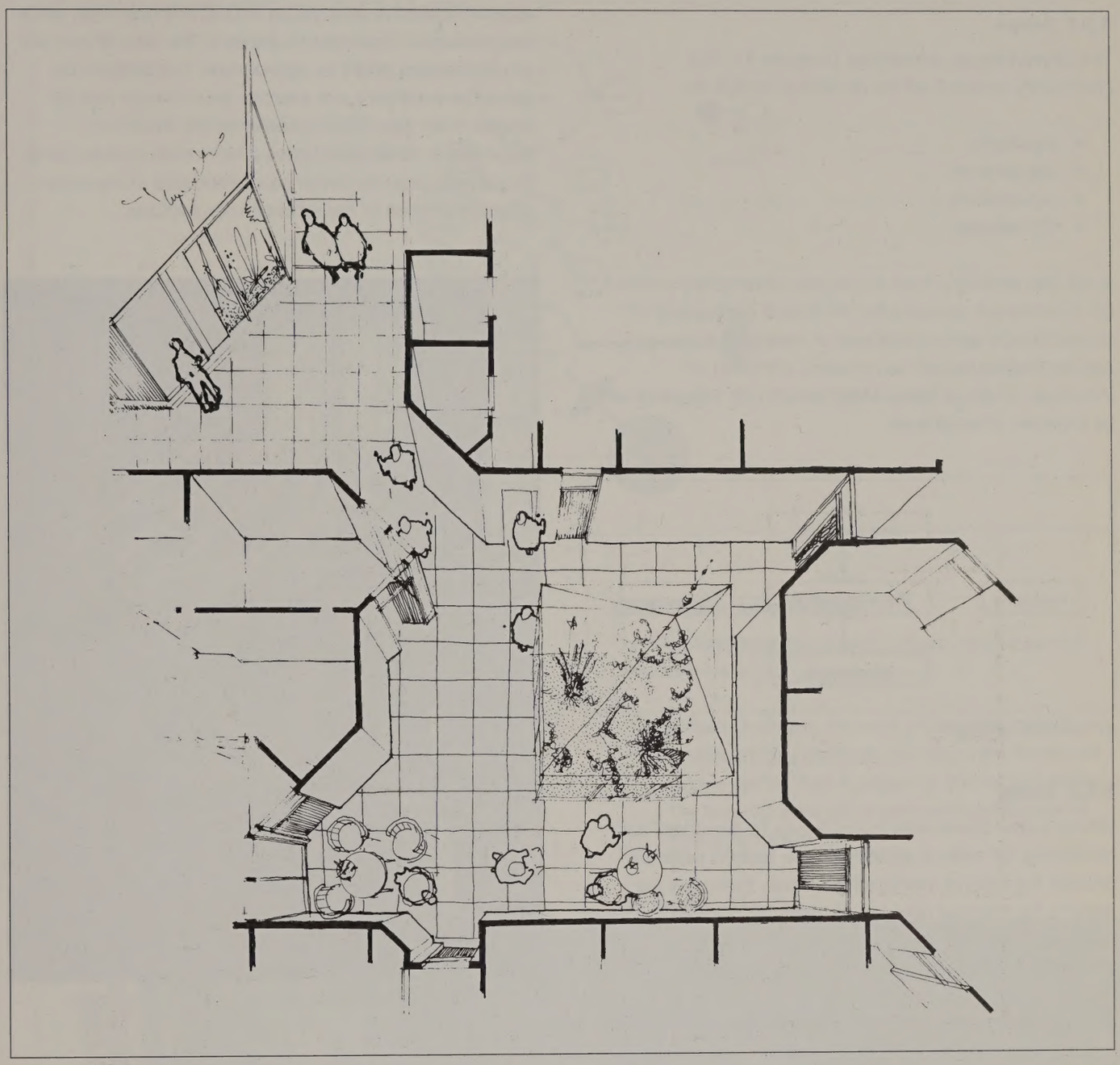


38. Layout of a core day hospital and its relationships to the OT, physiotherapy and speech therapy elements of the whole day hospital



39. View of the core day hospital and its relationship to the outdoor spaces. Note the central forum used as an informal meeting space

40. View of the central area in the day hospital rehabilitation zone showing ease of access between the various elements and back to the central hospital courtyard



9.2.7 Total quality management

The day hospital should provide:

- a quiet area for distressed patients, or those needing to withdraw temporarily
- adequate provision of WCs within 12m of main day and dining areas
- WCs which do not open directly on to spaces in which people may gather (e.g. day spaces)
- access to outdoor spaces and courtyards
- a choice of activities and locations
- an exterior outlook from day areas which provides interest and stimulus for patients.

9.2.8 Interior design

Issues here include:

- choice of furniture for the day area which represents an appropriate balance between function and aesthetics and which makes a positive contribution to the overall design
- informal seating arrangements in day and dining areas should be encouraged
- low tables, reading lights and decorative lighting in day areas can also contribute to an informal atmosphere.

9.2.9 Multi-use of space

Use of day hospital facilities by voluntary groups, during evenings and weekends, should be encouraged.

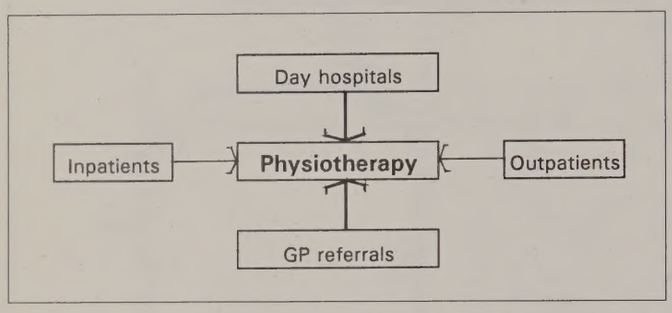
9.3 Physiotherapy

9.3.1 Scope

The physiotherapy service (see Diagram 41) in a community hospital will be providing services to:

- inpatients
- day patients
- out-patients
- GP referrals

It will also provide a base for outreach/domicilary services. GP referrals will generally be the largest component of physiotherapy service workload. A variety of active and passive treatments will be provided, either on an individual, or group basis. Many services for inpatients will be provided at ward level.



41. Source of workload

9.3.2 Sizing

Where a new community hospital is to be provided, data on existing GP referral patterns to the nearest DGH will provide the basis of workload estimates. Estimates may need to be adjusted upwards to allow for possible increases in referrals which may be generated by access to a local, rather than DGH, physiotherapy department.

The inpatient and outpatient components of community hospital physiotherapy workload may also be estimated from those services which are currently provided at the DGH and which may be expected to transfer to the community hospital.

Estimated workload will generate a need for a particular physiotherapy staffing establishment. The number of staff in the department at any time and the maximum number of patients that they can treat simultaneously will then form the basis for estimating total space requirements. Subdivision of space between the exercise area for group work, and the provision of cubicles, for individual treatment, will be a matter for local decision.

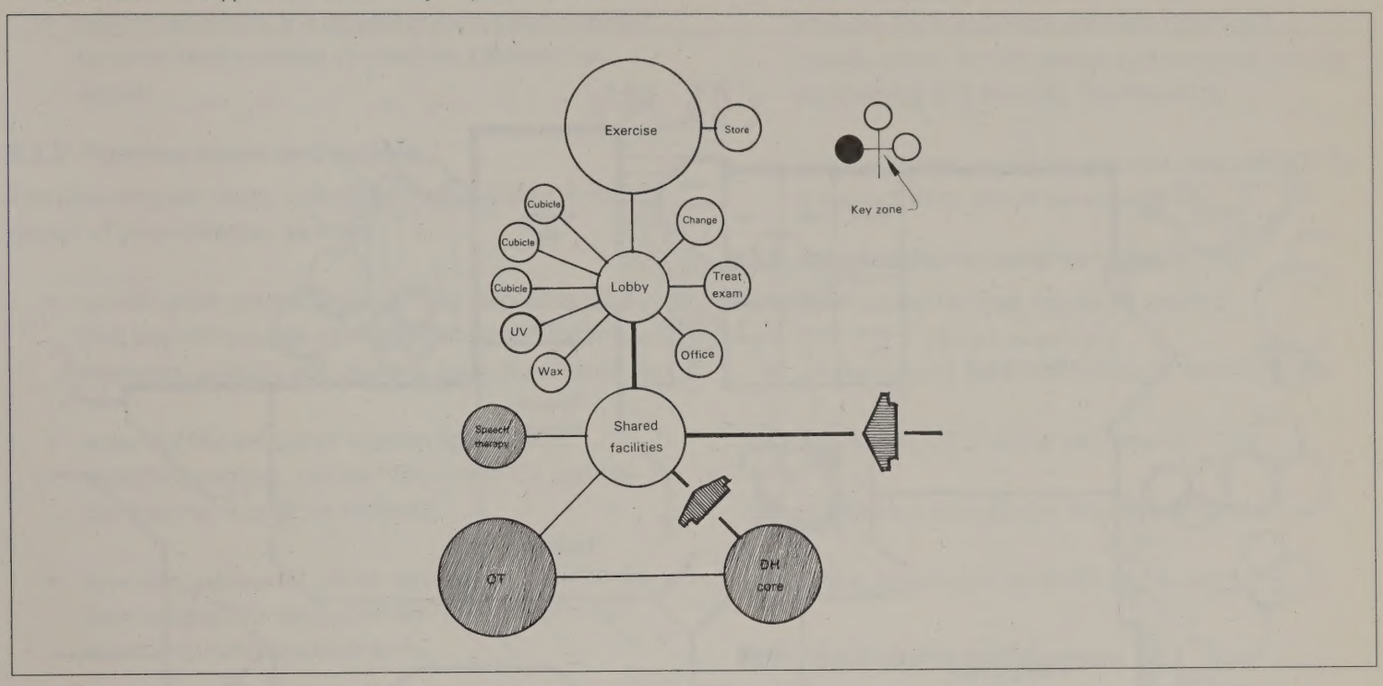
In a community hospital, it might be expected that groups of up to 12 patients with one or two staff might be accommodated in an exercise area at any one time, while the provision of treatment cubicles in the ratio of two per physiotherapist might be appropriate. Suggestions for sizing the treatment and exercise areas (which may be smaller than their DGH equivalents) are shown in Appendix 3. Antenatal classes which could contain up to 30 patients, may be better accommodated in the clinic area, rather than in the rehabilitation facilities.

42. Physiotherapy exercise area – Lambeth Community Care Centre

9.3.3 Other relevant guidance

Health Building Note 8 – 'Rehabilitation – accommodation for physiotherapy, occupational therapy and speech therapy' provides useful background information but is specifically oriented to rehabilitation services provided in district hospitals and is not directly applicable to the smaller scale and different mix of services provided in community hospitals. However, in those few instances where a hydrotherapy pool is to be provided, the HBN 8 guidance for this option is appropriate.

43. Physiotherapy. The physiotherapy section of the rehabilitation service comprises physiotherapy cubicles, wax and UV rooms, a treatment room and a large exercise area. This supplies services to the day hospital, in addition to inpatients and out-patients



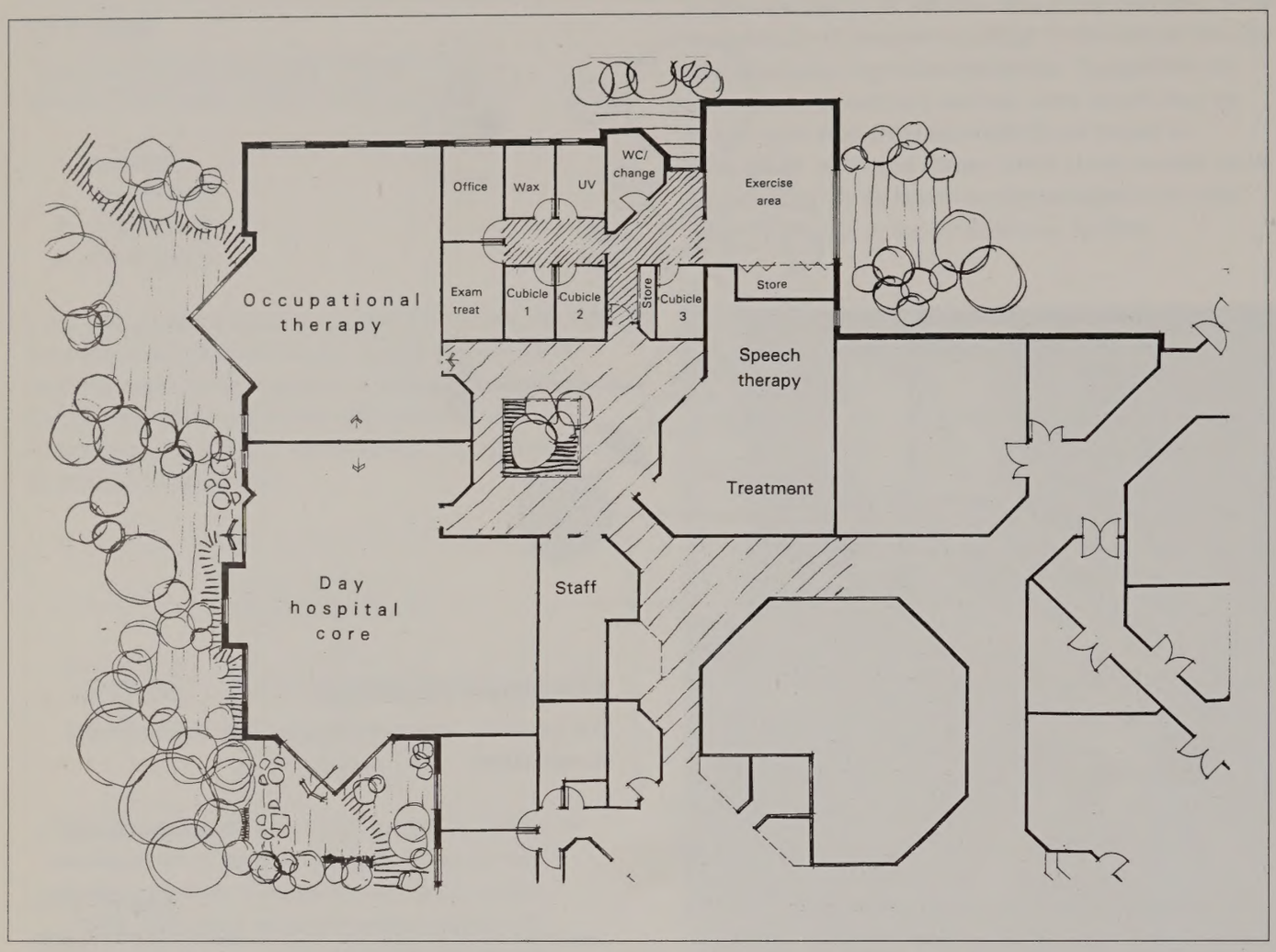
Health Building Note 37 provides guidance on physiotherapy, speech therapy and OT specifically associated with ward and day hospital accommodation for elderly people. It does not, therefore, deal with the wider service provided by these departments in community hospitals, (e.g. to other inpatients, out-patients, and most importantly, GP referrals). These guidance documents are, therefore, relevant as background material only.

9.3.4 Operational policies

The following operational policy issues require careful consideration:

- patient changing. Patients undergoing individual treatment may prefer to change in the treatment cubicle rather than in separate changing cubicles. The exercise area will require associated patient changing provision.

44. Physiotherapy exercise area – Ystradgynlais community hospital



45. Layout of a physiotherapy section showing its relationship to the other elements of the day hospital/rehabilitation area

- staff changing. Local changing may be preferred.
- patient reception. If a reception area is not provided, patients need a means of notifying staff of their arrival.

9.3.5 Planning issues and options

The following are issues to be taken into account in the design of physiotherapy facilities:

- overall space provision should take into account that physiotherapists cannot be working in wards, treatment cubicles and exercise areas simultaneously.
- scope for shared use of support spaces (e.g. reception, waiting, utilities, WCs) with OT and the day hospital should be explored.
- provision is required, either separately or within the exercise area, for physiotherapy staff to write up notes and make appointments.
- provision of a space to interview staff, or relatives, is desirable and could be shared with another department.
- flexibility to alter the balance between the exercise area and individual cubicles (e.g. to create additional cubicles for specific treatments) is desirable.
- provision of storage to accommodate items of furniture, wheelchairs, walking frames and consumables. Inadequate storage provision may restrict the capacity of treatment areas. Records can be stored in the main health records area.
- a hydrotherapy pool plus support accommodation may occasionally be provided in a community hospital. Such provision will have significant consequences for site energy consumption and for engineering and building maintenance.
- possible shared use of the exercise area with OT for group activities should be considered.

9.3.6 Relationship to other services

The physiotherapy facilities should be located:

- on the ground floor with access to exterior space
- adjacent to OT and the day hospital
- within easy access from the main entrance
- within reasonable proximity to the wards.

9.3.7 Total quality management

The physiotherapy facilities should provide:

- privacy for patients in individual treatment cubicles
- adequate ventilation for those individual treatment rooms containing heat generating equipment.

9.3.8 Multi-use of space

Shared provision and use of reception, waiting areas, utility areas WCs, etc, with OT and the day hospital, are possible and should be encouraged. Evening use of the exercise area for health education activities may also be possible.

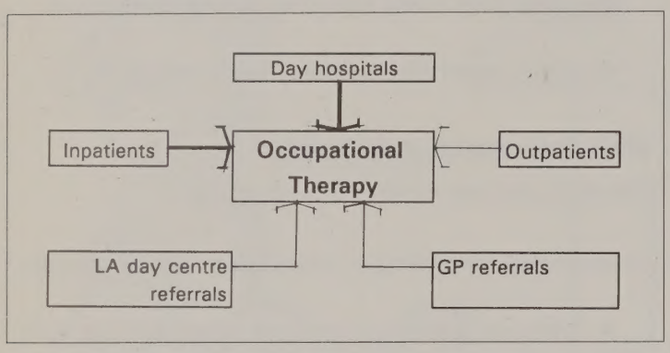
9.4 Occupational therapy

9.4.1 Scope

An occupational therapy (OT) service (see Diagram 46) in a community hospital will be providing services to:

- inpatients
- day patients
- out-patients/health visitor referrals
- GP referrals
- domiciliary services, assessments
- local authority day centre referrals.

Services to day patients, inpatients and GP referrals will generally be the largest components of OT workload.



46. Source of workload

The main focus for OT work will be assessment and treatment programmes for individual patients. Patients may also be grouped, for mental stimulation and support, to undertake particular activities and for effective use of OT staff time. Most patients will require a combination of aids to daily living (ADL) and group activities. The increased numbers of elderly patients is leading to a decreased focus of heavy/light workshop activities and to a greater emphasis of reality orientation and other less equipment intensive activities.

9.4.2 Sizing

A similar approach to that outlined for physiotherapy will generate the need for a given OT staffing establishment. The minimum number of staff in an OT department is likely to be one OT plus two helpers, who between them could cope with approximately 20–25 patients simultaneously.

Increased workload and staff will generate a need for a larger exercise area, but will not affect ADL provision (apart from increasing the usage of those facilities). The likely proportion of wheelchair patients will also affect the sizing of the exercise area.

Appendix 3 illustrates a method for sizing the department appropriately to the community hospital scale.

9.4.3 Other relevant guidance

See physiotherapy Chapter 9.3.3.

9.4.4 Operational policies

The following operational policy issues require careful consideration:

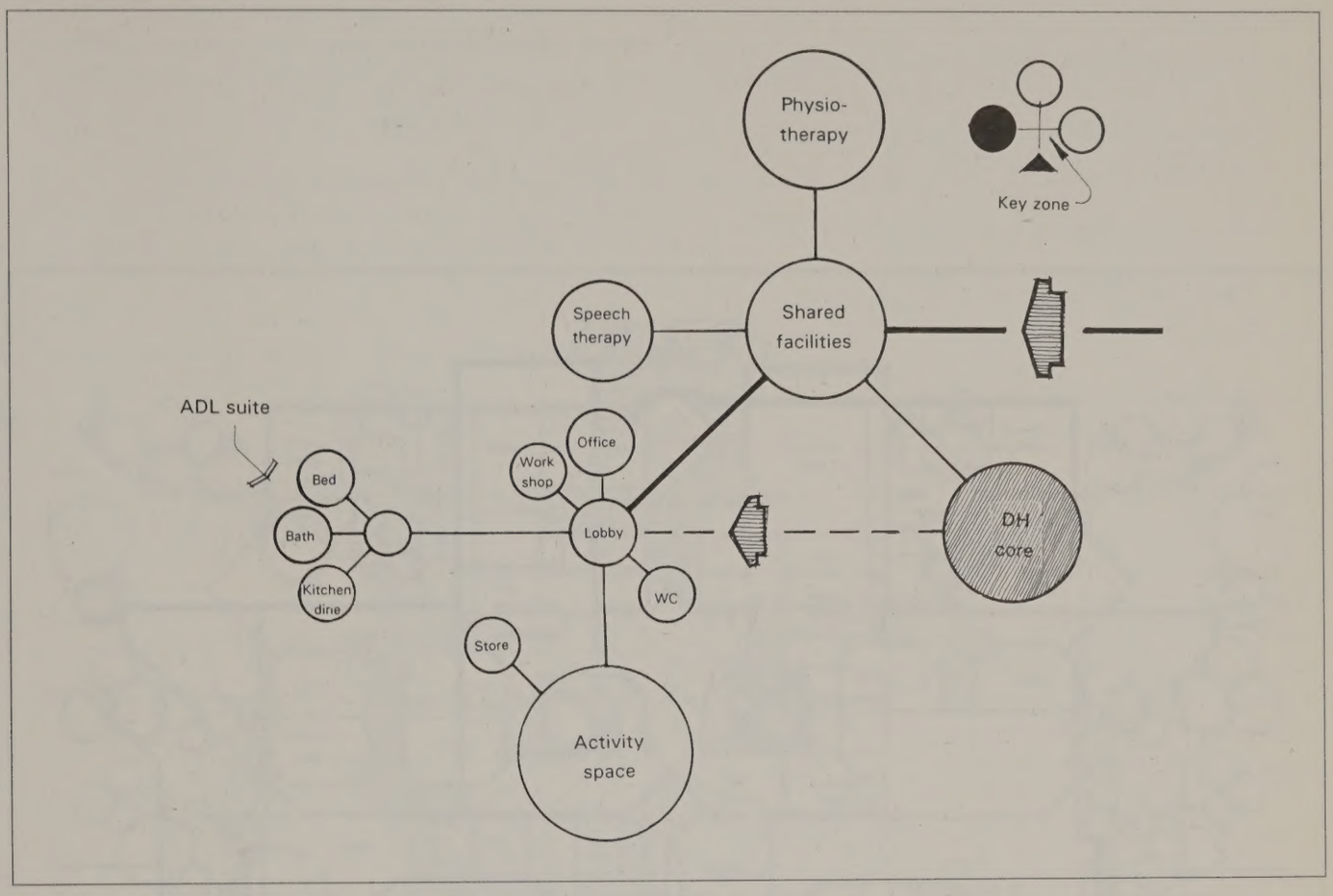
- range and nature of group activities to be provided
- staff changing. Local provision may be preferred.

9.4.5 Planning issues and options

The following are issues to be taken account of in the design of OT facilities:

- overall space provision should take into account that OT staff and helpers cannot be working in wards, ADL facilities, activity areas and in the day hospital simultaneously.
- scope for shared use of support services (e.g. reception, waiting, utilities, WCs, with physiotherapy and day hospital) should be explored.
- scope for shared use of exercise area with physiotherapy should be considered.
- provision of a space to interview staff, or relatives, separate from OT office, is desirable and could be shared with another department.
- flexibility to use the activity area for a wide variety of different types of activities is important. Provision of appropriate storage for equipment and supplies is essential to allow this to happen.
- direct access to the ADL spaces should be possible without going through the OT exercise area, in order to avoid disruption of patients engaged in group activities.

47. OT. The OT section of the rehabilitation service comprises ADL and activity spaces, supported by an OT office workshop, WCs and storage. Normally this forms part of the day hospital but can also be used independently by other out-patients and inpatients



9.4.6 Relationship to other services

The OT facilities should be located:

- on the ground floor with access to exterior space
- adjacent to physiotherapy and the day hospital
- within easy access for the main entrance
- within reasonable proximity to the wards.

9.4.7 Interior design

Issues here include:

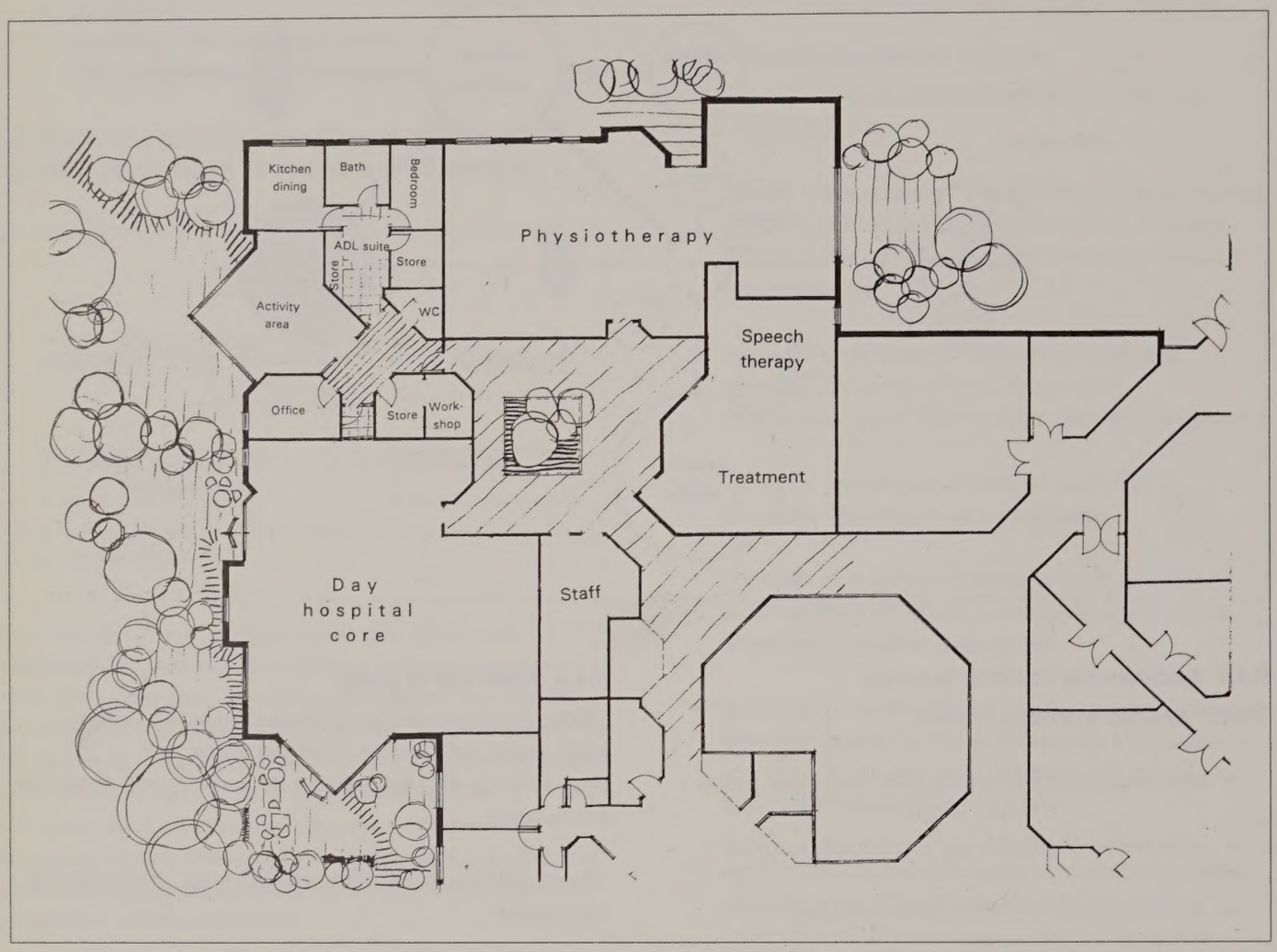
- the environment should be non-clinical, particularly in the ADL area. The ADL bathroom should be located adjacent to the ADL bedroom. The ADL kitchen should be an enclosed space rather than an open bay.

9.4.8 Multi-use of space

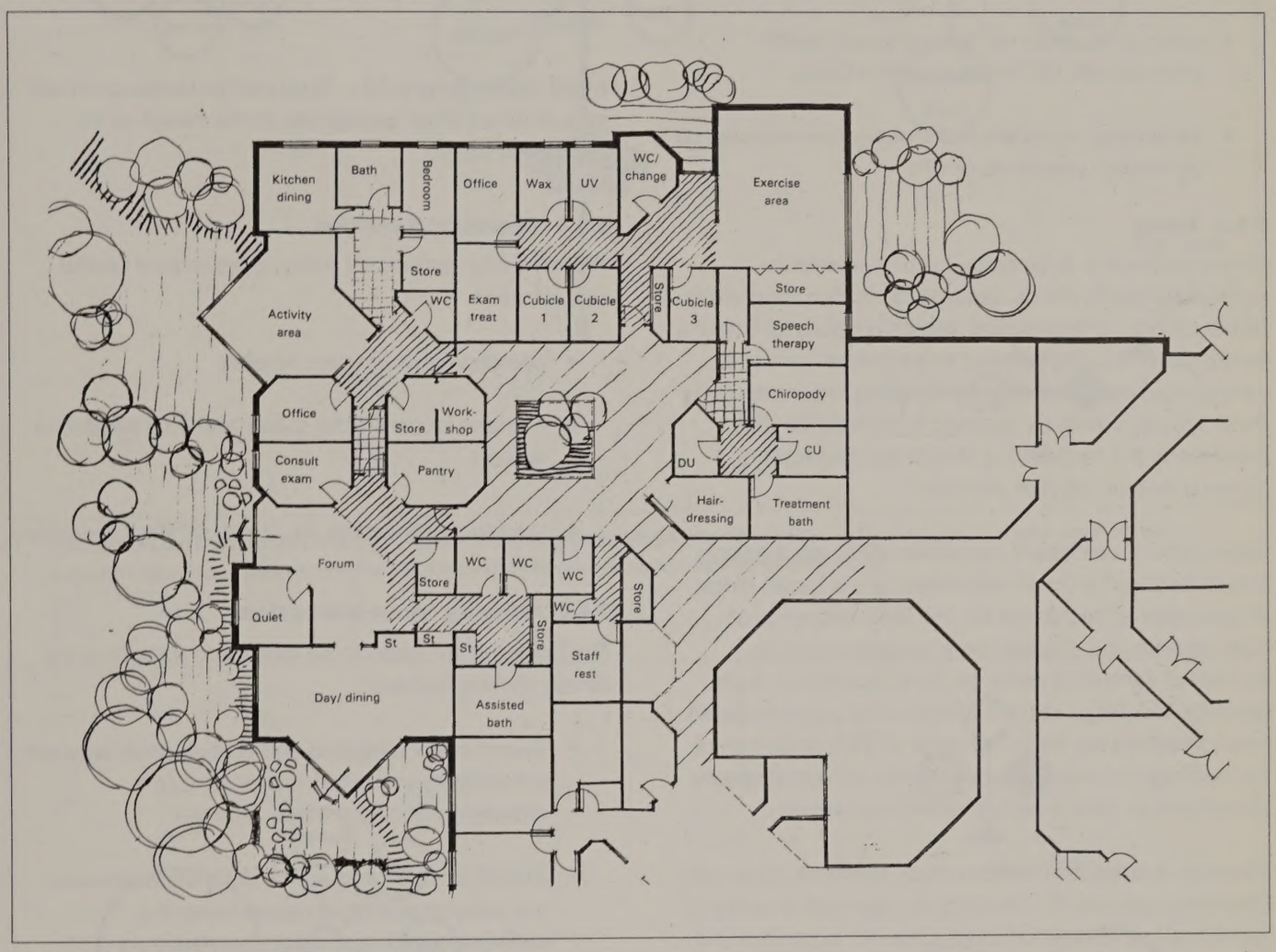
Shared provision and use of reception, waiting areas, utility areas, WCs and an interview space with physiotherapy and day hospital are possible and should be encouraged.

Shared exercise space, with physiotherapy, should also be considered.

48. ADL kitchen – Lambeth Community Care Centre



49. Layout of the OT section showing its relationships to the other elements of the day hospital/rehabilitation area



50. Layout of the whole day hospital/rehabilitation area

9.5 Clinic Services

9.5.1 Scope

Clinic services in a community hospital may include:

- consultant outpatient clinics in a variety of specialties (see Diagram 11)
- clinics run by GPs (e.g. cytology clinics)
- community clinics run by a variety of health professionals and including dental clinics
- endoscopy, treatment and investigation sessions run by visiting consultants or GPs.

9.5.2 Sizing

Where provision is to be made for GP surgeries or community health clinics, (because of existing shortfalls in health centre, surgery or clinic accommodation or where a health centre is being planned as an integral part of a community hospital development), space requirements for these services should be assessed in accordance with guidance in the forthcoming Health Building Note 46 – 'General medical practice premises'.

Assessment of consultant out-patient clinic requirements should be based on local assessment of the target range of specialties to be catered for, the likely frequency of clinic sessions and possible room usage pattern (i.e. number of consulting suites per clinic session) for each specialty. The actual range of clinics to be accommodated may sometimes not be known prior to the completion of the building and may be dependent on attracting specific consultants to work in a local community setting.

Planning of outpatient facilities must, therefore, cope with uncertainty, provide the flexibility to cope with a variety of specialties and also allow future scope for expansion and for the further development of treatment and investigation services.

9.5.3 Other relevant guidance

Health Building Note 12 – 'Outpatient department' (and the supplement on GUM clinics) are relevant sources of general guidance, but focus on the requirements of the much larger outpatient departments to be found in acute hospitals. The sizing methodology provided as an Appendix to HBN 12 may be applied to community hospitals. The assumptions in HBN 12 on clinic throughput, room usage, number of doctors per clinic session, etc should be modified to reflect the likelihood that outpatient clinics in community hospitals will involve fewer doctors, fewer patients who need to change, and a reduced requirement for access to diagnostic services, compared to out-patient clinics in acute hospitals.

HBN 46 – 'General medical practice premises' (in preparation) is the appropriate source of guidance on the provision of space for GP surguries and community health clinics.

Health Building Note 52 – 'Day Unit' (in preparation) will include information appropriate to the design of an endoscopy suite.

9.5.4 Operational policies

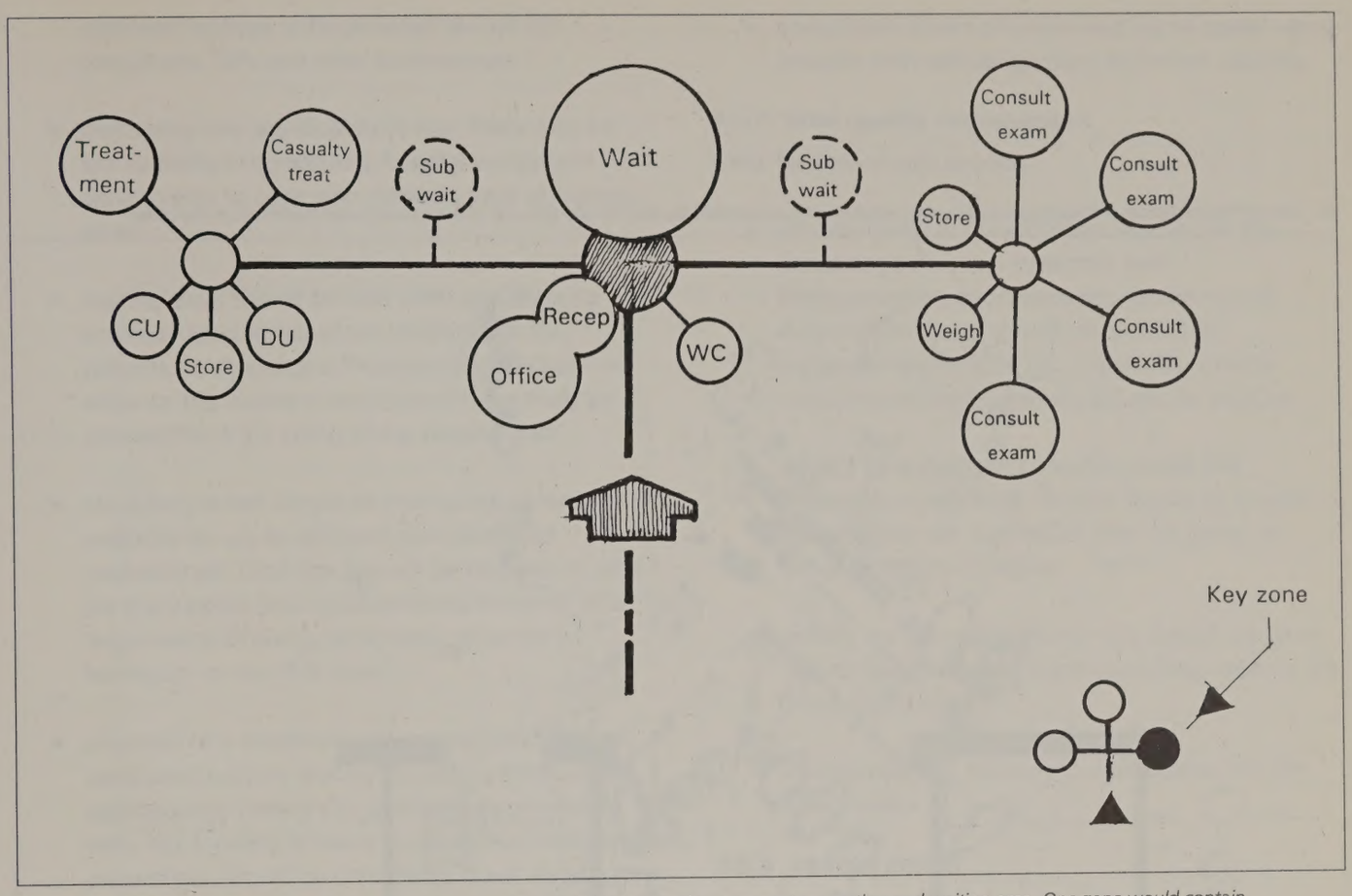
The following operational policy issues require careful consideration:

- opening hours for clinic services
- numbers of consulting rooms allocated per doctor session
- storage of equipment for use by different specialties

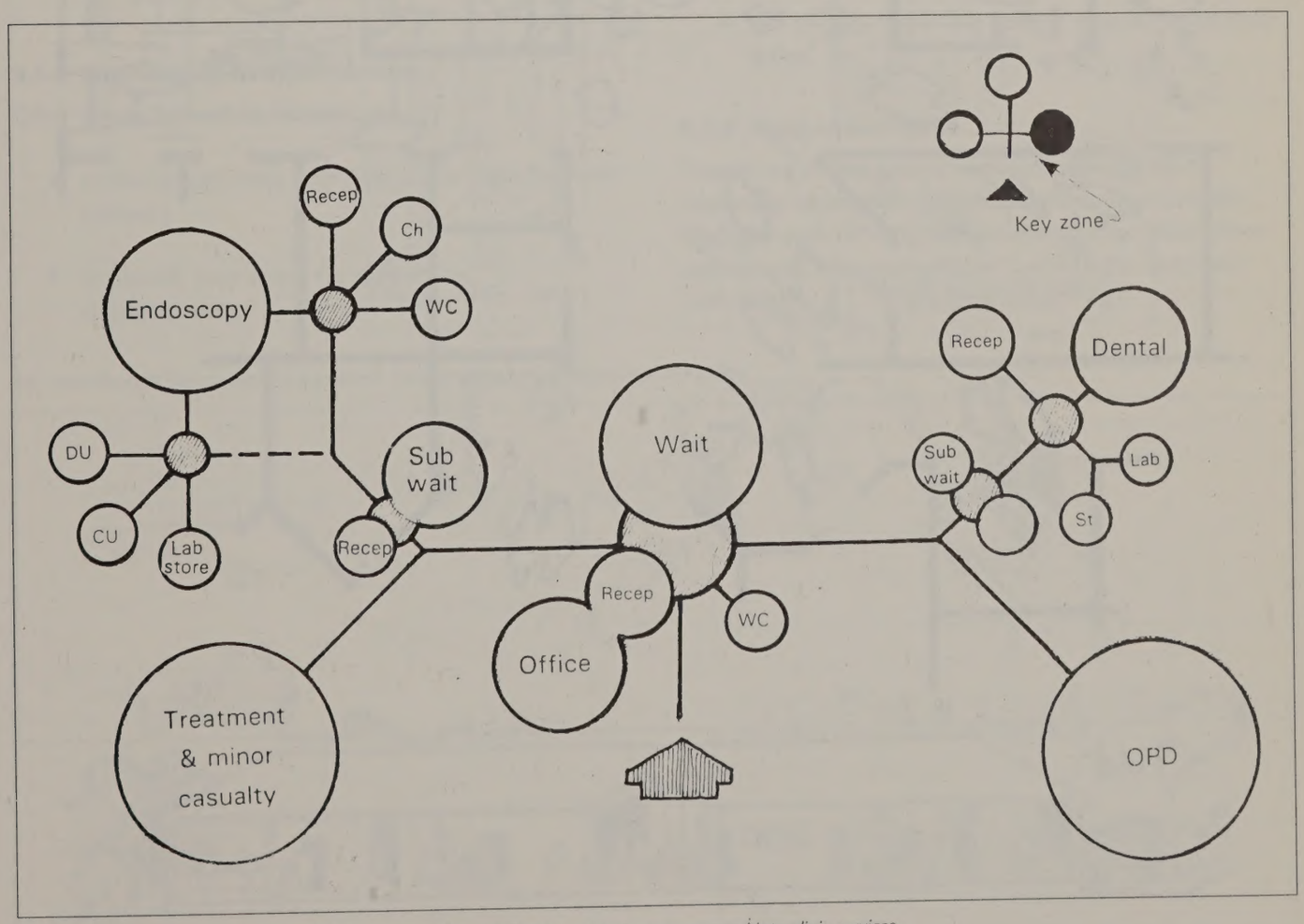
9.5.5 Planning issues and options

The following are issues to be taken into account in the design of clinic facilities:

- shared use of reception and waiting areas between out-patients and other departments (e.g. radiodiagnostics and minor casualty).
- shared provision and use of utility areas between out-patients and other departments (e.g. radiodiagnostics and minor casualty).
- type of consulting suites provided. Combined consulting and examination rooms will provide more flexibility in use than separate consulting and examination rooms.
- possible shared provision and use of treatment and utility areas between outpatient clinics, GP surgeries and community clinics, where the latter are to be provided as an integral part of a community hospital development. Shared provision may enable

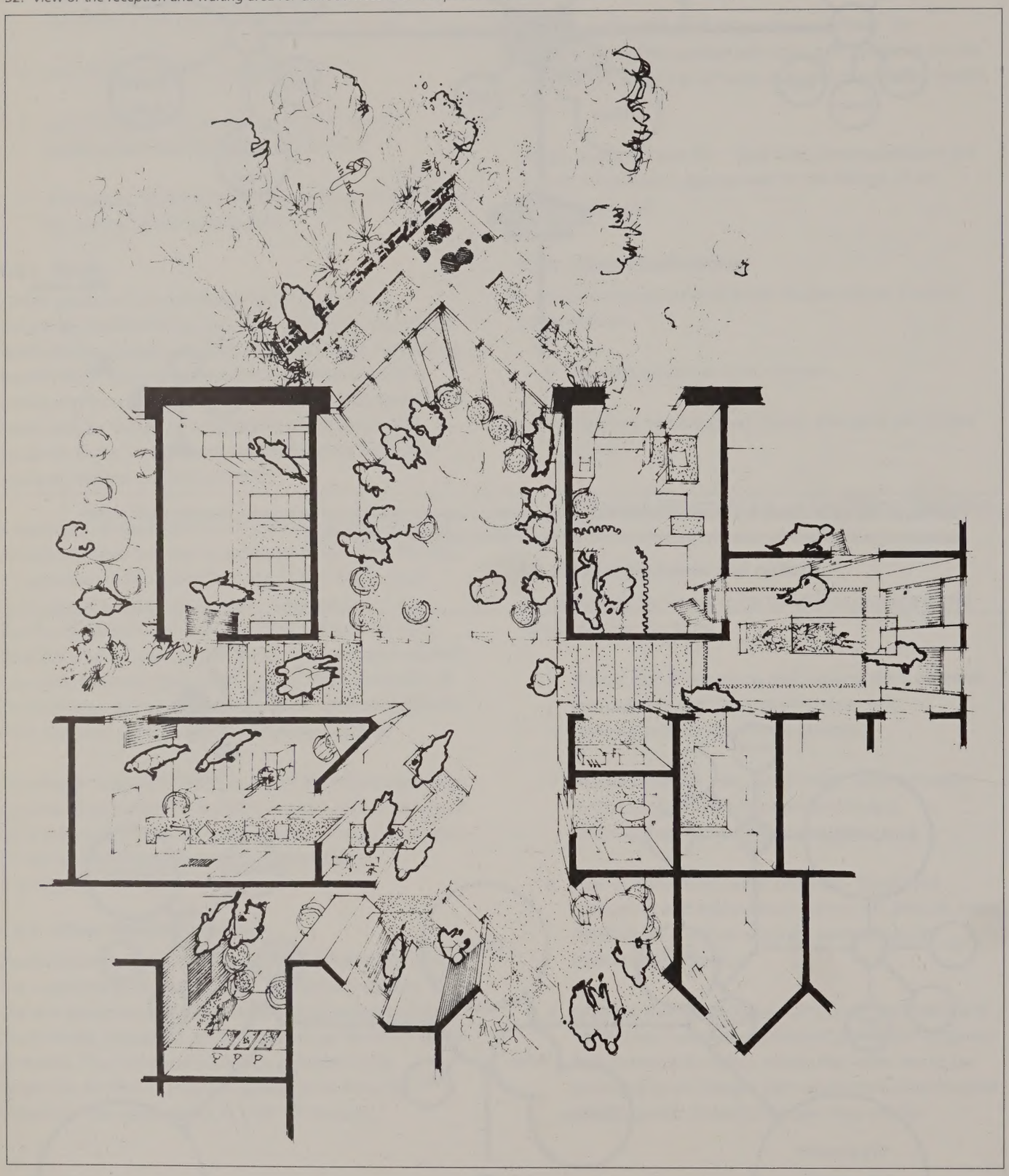


51.1 Clinic services and minor casualty in a small community hospital incorporating a separate reception and waiting area. One zone would contain out-patient services and another zone the treatment and minor casualty rooms supported by utility spaces



51.2 In a larger community hospital, endoscopy and dental facilities might be incorporated into clinic services

52. View of the reception and waiting area for clinic services with out-patient facilities to one side and minor casualty and treatment to the other



improved facilities to be provided for use by consultants, GPs and other professionals.

- clinics may vary significantly in size. There may be less flexibility in community hospital out-patient departments to cope with peaked usage of waiting areas.

- waiting areas should provide adequate space for accompanying relatives and children and for patients in wheelchairs. Provision of easy chairs will enhance the quality of environment, but must be allowed for in the sizing of the waiting area.

- consulting suites should be multi purpose, and available for use by different specialties and professionals. Local storage will be required to cater for the supplies and equipment requirements of a large variety of clinics, which may occur on a fortnightly or monthly basis.

- provision of a treatment and endoscopy suite (with associated support spaces) for programmed use by appropriately trained GPs and visiting consultants, to carry out a variety of minor surgical and investigative procedures, should be considered. It will also be essential to ensure that sterilising and disinfecting equipment and procedures comply with the requirements of good manufacturing practice.

9.5.6 Relationship to other services

Clinic services should be located:

- on the ground floor with easy access from the main entrance

- to provide easy access for patients to radiodiagnostics

- to facilitate shared provision and use of space where possible with radiodiagnostics and minor casualty.

9.5.7 Total quality management

Clinic facilities should provide:

- confidentiality at the reception area and in the consulting suites and treatment area. Interconnecting doors between consulting and examination rooms should be avoided (as recommended in HBN 12). Subwaiting directly outside consulting suites should also be avoided.

- privacy for patients in consulting suites and treatment areas. These facilities should be located so that they are not overlooked from car parks, or other parts of the hospital.

- privacy for changed patients who should not have to pass public areas to reach consulting suites or the endoscopy suite.

- a ventilated and naturally lit waiting area with an exterior view.

9.5.8 Interior design

Issues here include:

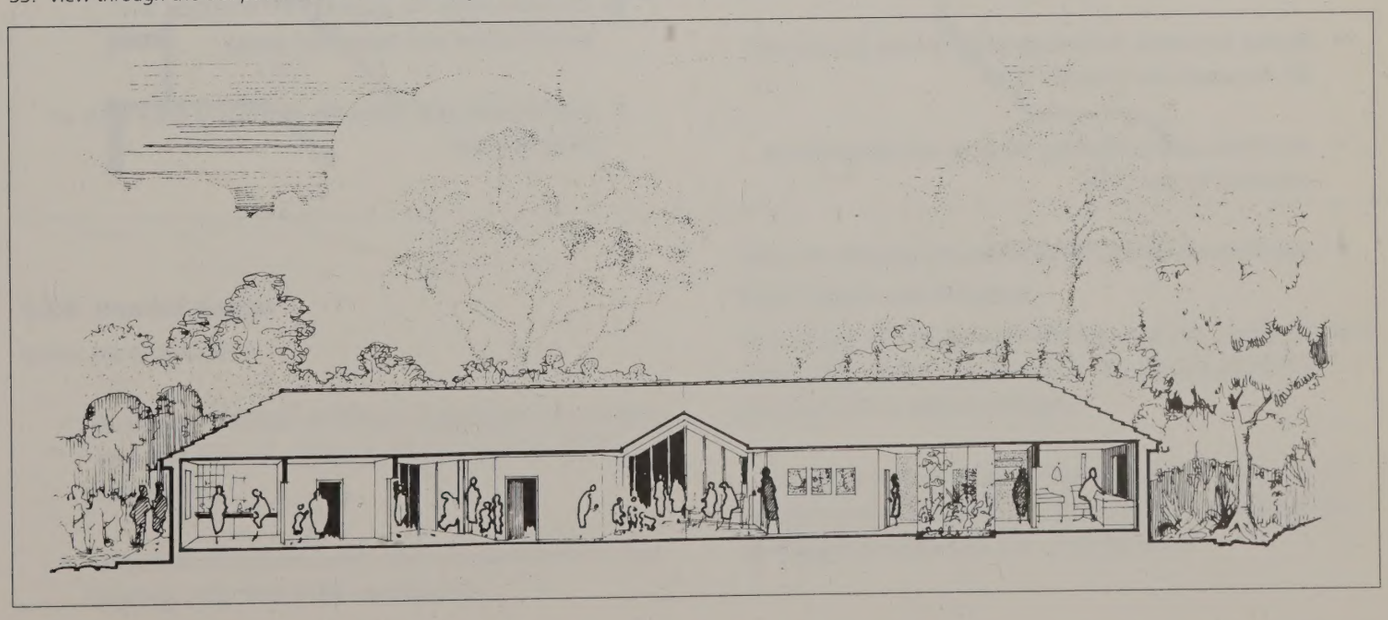
- choice of furniture for the waiting area

- use of carpeting in the waiting area and consulting suites.

9.5.9 Multi-use of space

Shared use of the waiting area, reception, utilities, treatment spaces with radiodiagnostics, minor casualty (and also with GP surgeries and community clinics where appropriate) may make efficient use of both space and staff time.

53. View through the out-patients and minor casualty with waiting/reception at the centre



9.6 Minor casualty

9.6.1 Scope

The scope of services provided will vary according to local circumstances (e.g. tourism, particular local hazards availability of other facilities, etc) and on the skills and expertise of available staff.

A minor casualty service in a community will provide treatment by GPs and nurses of "walking wounded" patients with minor injuries. More serious cases will be taken directly to the nearest DGH. Patients will generally be self referred. Some follow up patients may be referred from other District General Hospitals for plaster checks, etc. Patients attending minor casualty will generally be discharged home.

9.6.2 Sizing

The minimum provision for a minor casualty service is a single examination/treatment room, with associated support spaces (e.g. utility, WC, waiting area). Provision of additional examination treatment cubicles should be based on local assessments of demand in terms of likely numbers of patients per day.

9.6.3 Other relevant guidance

Health Building Note 22 – 'Accident and emergency department' is of general background interest only, as it focuses on DGH accident and emergency departments.

9.6.4 Operational policies

The following operational policy issues require careful consideration:

- provision of daytime only, day and evening or 24 hour service. This will have implications for nursing and GP cover
- organisation of medical cover. This may be provided in a variety of ways including sessional cover, and on-call rotas by different GPs/practices
- access to a basic radiodiagnostic service on site will be required (see Chapter 9.7)
- pharmacy and pathology services will generally be provided by the DGH
- out-of-hours access by patients and security for staff
- staff changing. Local changing may be preferred.

9.6.5 Planning issues and options

The following are issues to be taken into account in the design of minor casualty accommodation:

- scope for shared use of waiting area, reception and utility areas with out-patients or radiodiagnostics
- access to a room for private discussions with relatives will be necessary
- clear signposting from the main entrance and clearly visible instructions on how patients should gain out of hours access. A separate minor casualty entrance will not normally be required.

9.6.6 Relationship to other services

The minor casualty facilities should be located:

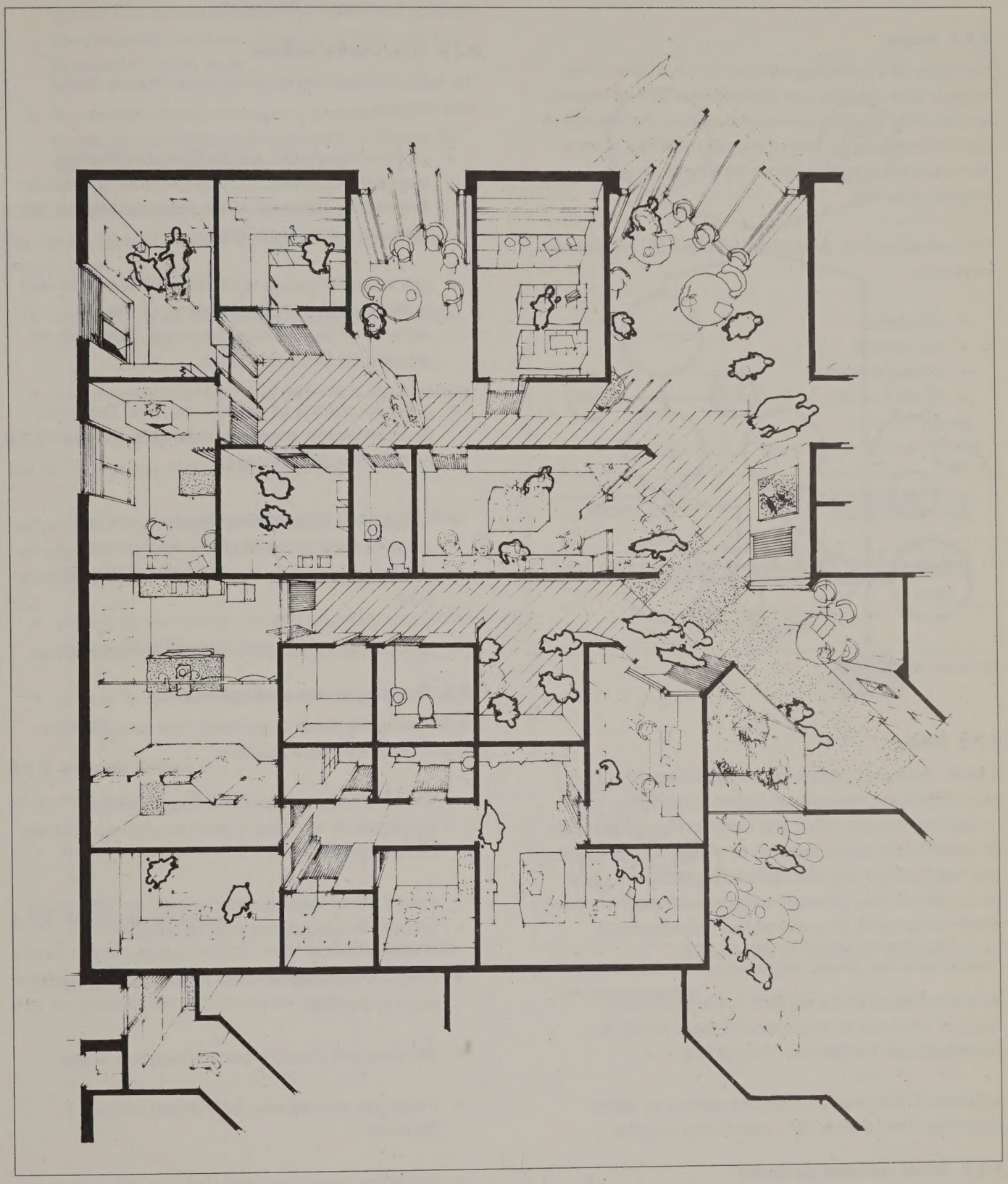
- on the ground floor with easy access from the main entrance
- in close proximity to radiodiagnostics and out-patients
- within reasonable access to one of the wards, for possible provision of nursing cover for those few patients attending out of hours.

9.6.7 Total quality management

The minor casualty facility should provide:

- clear signposting from the main entrance
- a welcoming reception point for distressed patients
- privacy for patients in examination and treatment areas. Care should be taken to avoid overlooking from waiting areas
- confidentiality for patients in reception and examination and treatment areas
- a ventilated and naturally lit waiting area with an external view

54. View of the minor casualty and treatment areas adjacent to the radiodiagnostic department



9.6.8 Interior design

Issues here include:

- choice of furniture and floor covering in the waiting area, can help to create a reassuring and relaxing atmosphere
- provision of pictures and other visual interest in the waiting area should be considered

9.6.9 Multi-use of space

Shared use of support spaces (e.g. waiting, treatment and utility areas) with out-patients and radiodiagnostics is possible and to be encouraged.

Joint staffing of a shared reception area between minor casualty and out-patients may sometimes be appropriate to make most effective use of staff time.

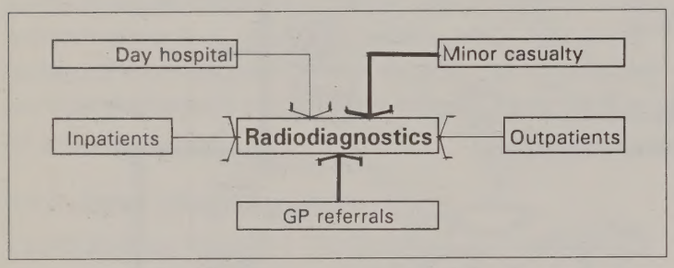
9.7 Radiodiagnostics

9.7.1 Scope

The scope of a radiodiagnostic service in a community hospital (and whether one is provided at all) will depend on the range of other services provided in the hospital. A basic radiodiagnostic service (mostly chest and skeletal examinations) may be augmented to provide an ultrasound facility.

The radiodiagnostic service (see Diagram 55) will provide services to:

- inpatients
- out-patients
- direct GP referrals
- minor casualty
- day hospitals



55. Source of workload

9.7.2 Sizing

A basic service will consist of one radiodiagnostic room plus support accommodation (waiting, changing, utility, processing, storage, office and reception). Approximately 30 patients/day will be required to make effective usage of one radiographer and one radiodiagnostic room. Local circumstances may generate a higher estimated workload which could justify provision of two radiodiagnostic rooms, but this is unlikely to be common.

Where antenatal clinics are held in the community hospital, provision of an ultrasound room within the radiodiagnostic facilities may be justified.

Appendix 3 illustrates a suggested method of sizing radiodiagnostic services for a community hospital.

9.7.3 Other relevant guidance

Health Building Note 6 – 'Radiodiagnostic department' provides guidance which is of relevance to community hospitals, particularly with regard to the design of the radiodiagnostic room.

Health Circular HC(89)18 provides guidance on health service use of Ionising Radiations.

9.7.4 Operational policies

The following operational policy issues require careful consideration:

- provision of services and facilities should satisfy statutory requirements under the Ionising Radiation Regulations 1985 and 1988 and should follow the guidance set out in HC(89)18
- procedure for reporting on films. Films may be sent to the nearest DGH for reporting, or may be reported on by a visiting radiologist. Space will be required for this latter option.
- policy for storage of records and films. These may be stored within the department or in the health records area of the hospital
- reception of patients. This department is likely to be single handed and procedures may be necessary for dealing with arriving patients, if the radiographer is busy
- staff changing. Local provision should be assumed.

9.7.5 Planning issues and options

The following are issues to be taken into account in the design of radiodiagnostic facilities:

- shared office provision for radiographer and radiologist (if reporting is done locally) will generally be appropriate
- shared use of waiting areas, utilties, etc with minor casualty or out-patients may be possible
- a WC immediately adjacent to the radiodiagnostic room is desirable
- WC provision should provide wheelchair access
- a separate waiting area for changed patients is desirable
- circulation space and room sizing should provide adequate access by wheelchair patients

- the film processing machine should ideally be located in a dedicated space. This space will need to be adequately ventilated. Viewing facilities can also be provided in this room

- If a separate ultrasound room is provided, this should also be adequately ventilated. A shower for use by patients may also be desirable.

9.7.6 Relationships to other services

The radiodiagnostic facilities should be located on the ground floor:

- with easy access from minor casualty and from the main entrance

- convenient access from out-patients is also desirable.

9.7.7 Total quality management

The radiodiagnostic facilities should provide:

- privacy for changed patients, who should not have to pass through public areas, to reach the radiodiagnostic room

- privacy for patients in changing cubicles and secure storage of personal clothes

- privacy for patients in radiodiagnostic or ultrasound rooms.

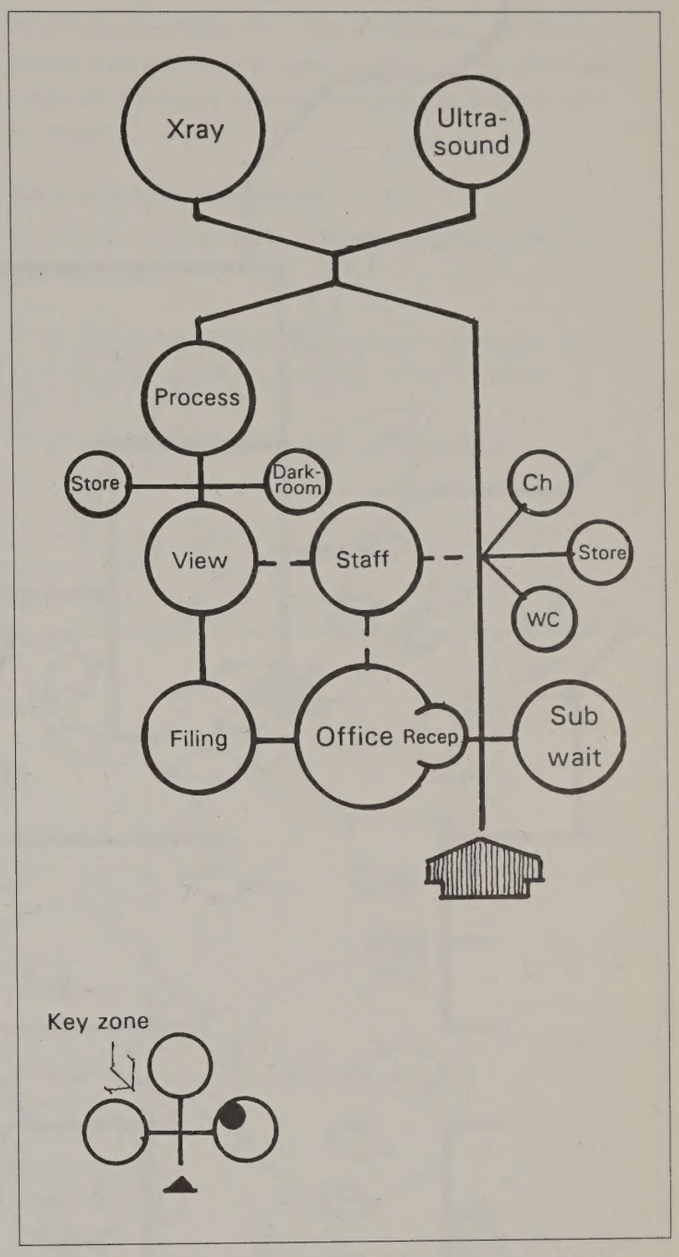
9.7.8 Interior design

Issues here include:

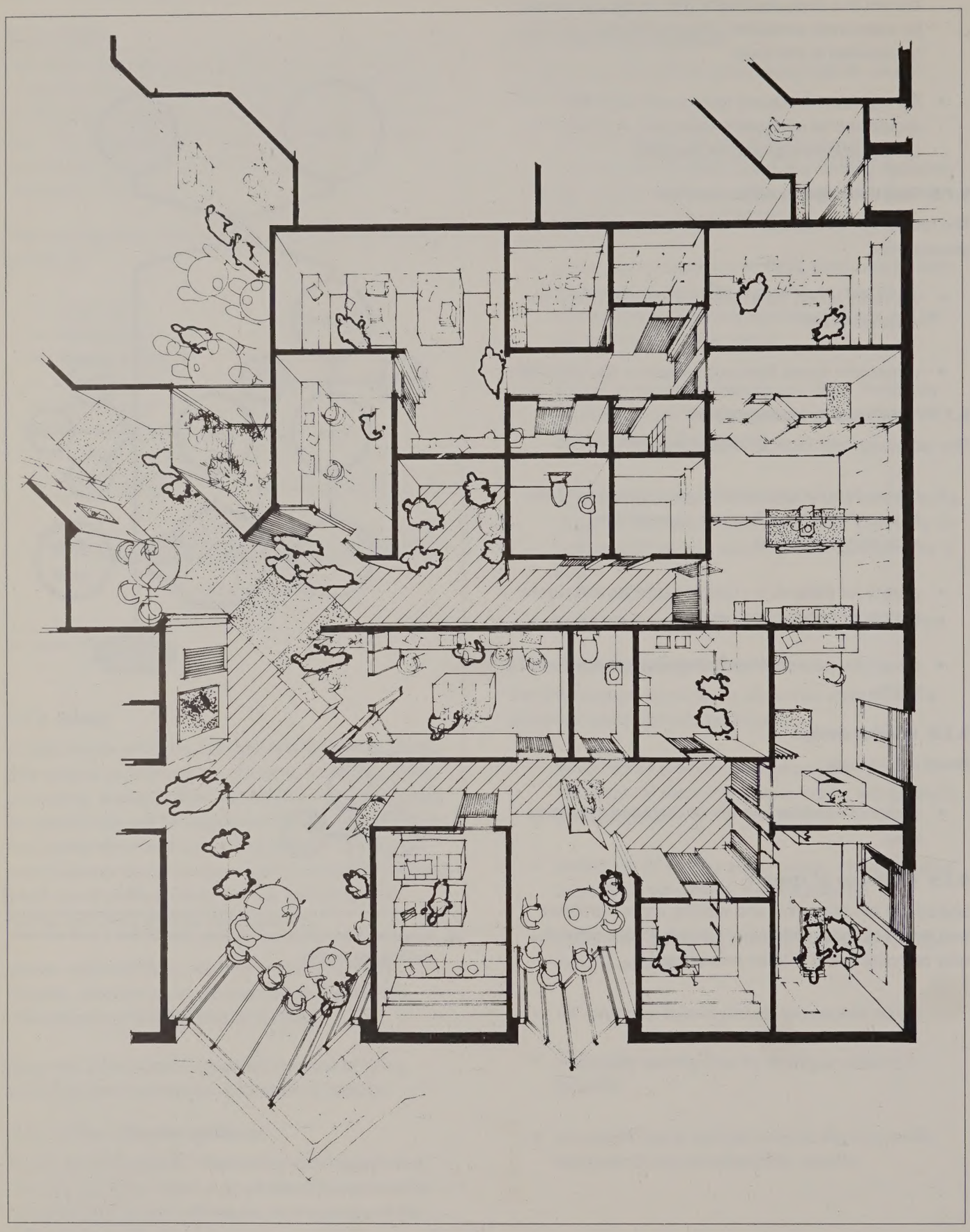
- choice of furniture and use of carpeting in waiting area.

9.7.9 Multi-use of space

Shared use of utility areas and waiting space, reception and record storage, with minor casualty or out-patients may be possible and is to be encouraged.



56. A single RD room with support facilities. Patients need a small sub-wait and changing facilities



57. View of radiodiagnostics showing separate reception and sub-wait. Note the separation of circulation for staff and patients

9.8 Main entrance area

9.8.1 Scope

The main entrance area of a community hospital may accommodate a wide variety of activities:

- main reception and waiting area. This may be shared with outpatients, day hospital or minor casualty
- wheelchair park
- pram park
- mother and baby room
- vending machines – tea bar
- porter's base
- pharmacy (dispensing)
- a shop and other income generating activities
- WCs for patients and visitors
- payphones

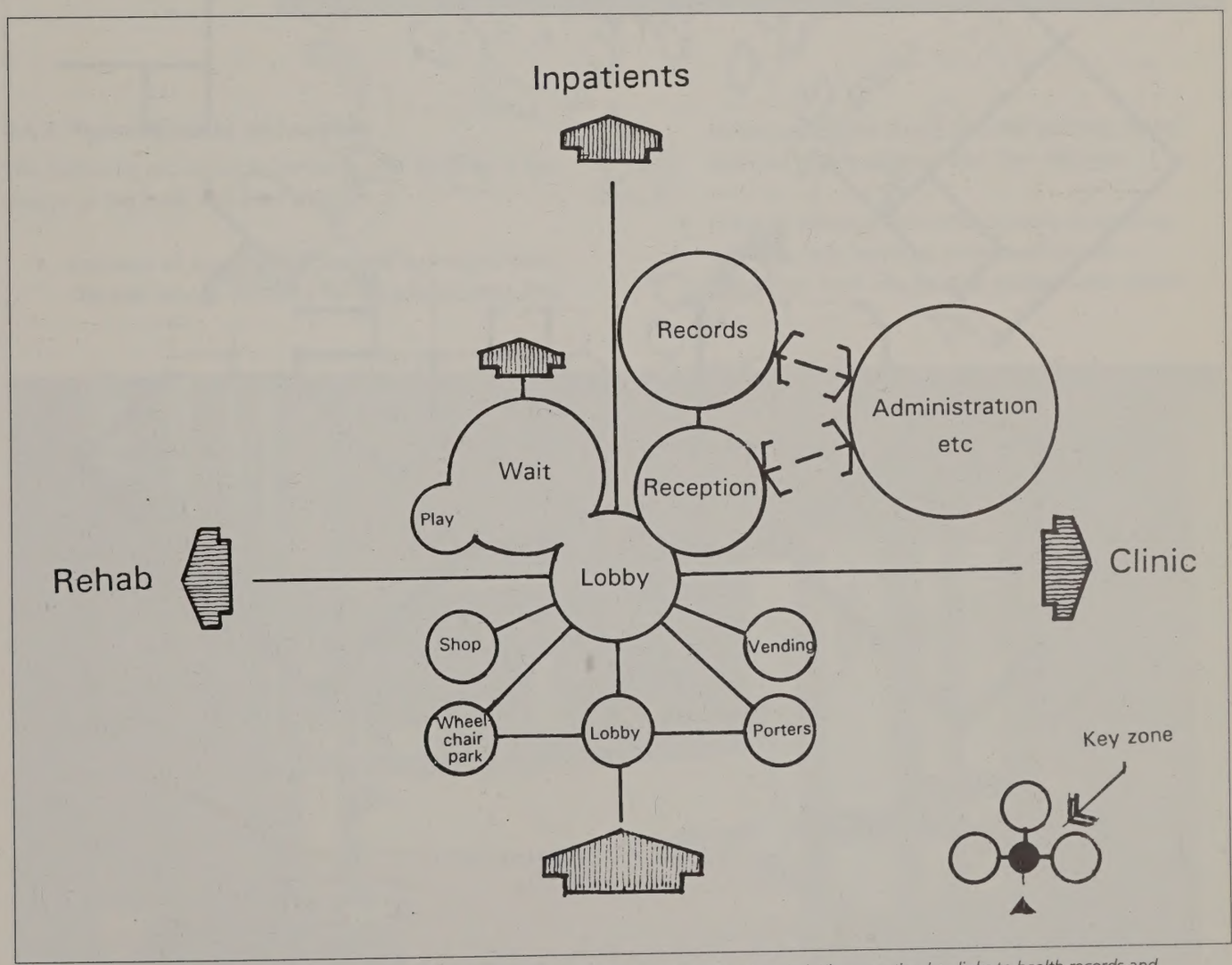
9.8.2 Other relevant guidance

Health Building Note 51 – 'Accommodation for the main entrance of a DGH' is of general relevance to community hospitals, although intended primarily for larger acute hospitals.

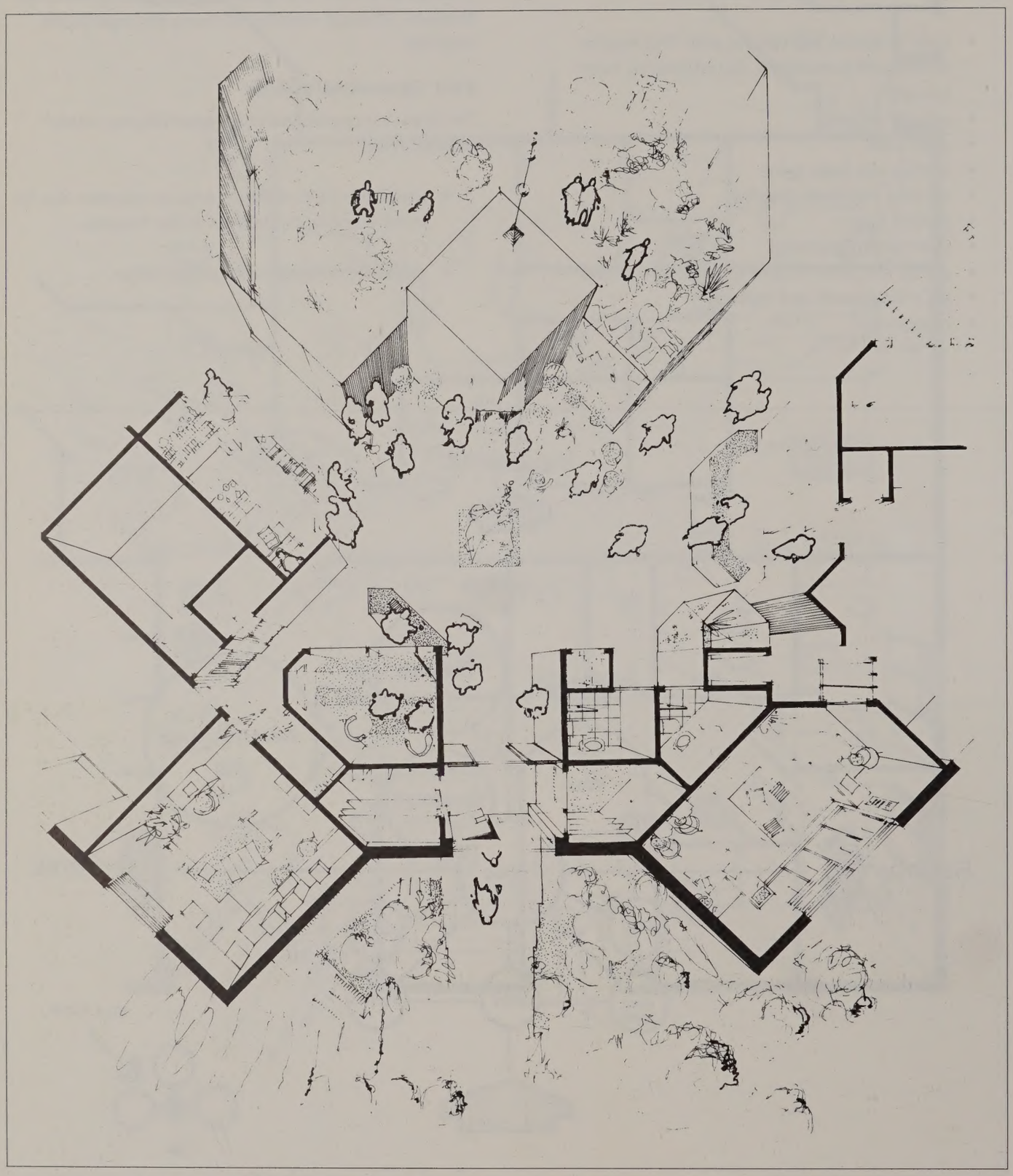
9.8.3 Operational policies

The following operational policy issue requires careful consideration:

- use of the main reception area as reception also for minor casualty, outpatients or day hospital.
- combined reception and general office.



58. The main entrance provides a focus of circulation to the major elements of the community hospital. The reception has links to health records and administration



59. View of the main entrance, central lobby and internal courtyard. This provides an informal meeting area and a focus of hospital circulation

60. *Main entrance – Lambeth Community Care Centre*

9.8.4 Planning issues and options

The following are issues to be taken into account in the design of the main entrance area:

- provision of automatic doors and a draught lobby. This will reduce draughts for waiting patients and visitors and make access into the building easier, both for elderly patients and their relatives
- siting of the shop and other income generating activities, (e.g. optician, pharmacy) should encourage their use by staff, patients and visitors.

61. *Main reception – Ystradgynlais Community Hospital*

62. *Main waiting – Bridlington Community Hospital*

9.8.5 Relationship to other services

The siting of the main entrance area should provide easy access into the building for day patients, out-patients, minor casualty, rehabilitation and radiodiagnostic patients. The distance from the main entrance area to inpatient accommodation should also be kept to a minimum, for the convenience of relatives and visitors, many of whom may themselves be elderly.

The main entrance should also be sited to provide convenient access from car parking areas.

9.8.6 Total quality management and interior design

The main entrance area should provide:

- a welcoming non clinical environment, which is commensurate with the ethos of a community hospital
- an environment in which creative use is made of colour, lighting, texture, pattern, artworks and plants
- a choice of furniture which contributes to, rather than detracts from, the overall effect
- patient WCs which do not open directly on to spaces in which people may gather
- a waiting area which is ventilated, naturally lit and has an external view
- direct access where possible to courtyards or the hospital grounds.

63. *Central atrium – Ystradgynlais Community Hospital*

9.9 Catering and staff dining

9.9.1 Scope

Kitchens in community hospitals provide meals for inpatients, day patients and staff. In some community hospitals the staff dining area is also open to local residents as an income generating activity.

Staff dining areas generally provide a daytime meal and beverage service for staff with evening and night-time service provided from vending machines.

9.9.2 Sizing

The options chosen for meal preparation (conventional, cook-chill, cook-freeze, use of ready made conventional or frozen meals) will have some effect on the overall size of the kitchen, as will the meal delivery system (bulk or plated). For example, a cook-chill system may require 10%–15% less space in the hospital main kitchen, when meals are supplied by an off-site central processing unit and plated in the hospital.

The community hospital may be expected to provide under 200 midday meals, and so the kitchen cannot necessarily be sized on the same basis as for an acute hospital. There will probably be relatively fewer cooks and supervisory staff, so some preparation areas may be more domestic in scale, and less office space will be needed.

Calculation of demand will require careful consideration. Bed occupancy rates can fluctuate widely in small hospitals, and it may be advisable to assume 100% bed occupancy, unless actual peak demand data are available. Day patients may attend for either a morning or afternoon session, but in both cases may stay for lunch, and so a minimum of 120% of day place occupancy should be assumed. Staffing levels in community hospitals suggest a ratio of one staff midday meal per two occupied beds, but where the proportion of part-time female staff is high and they are close to home, demand for staff meals may be somewhat less. Demand from visitors and possible use by the public should also be estimated in order to size the staff dining area.

9.9.3 Other relevant guidance

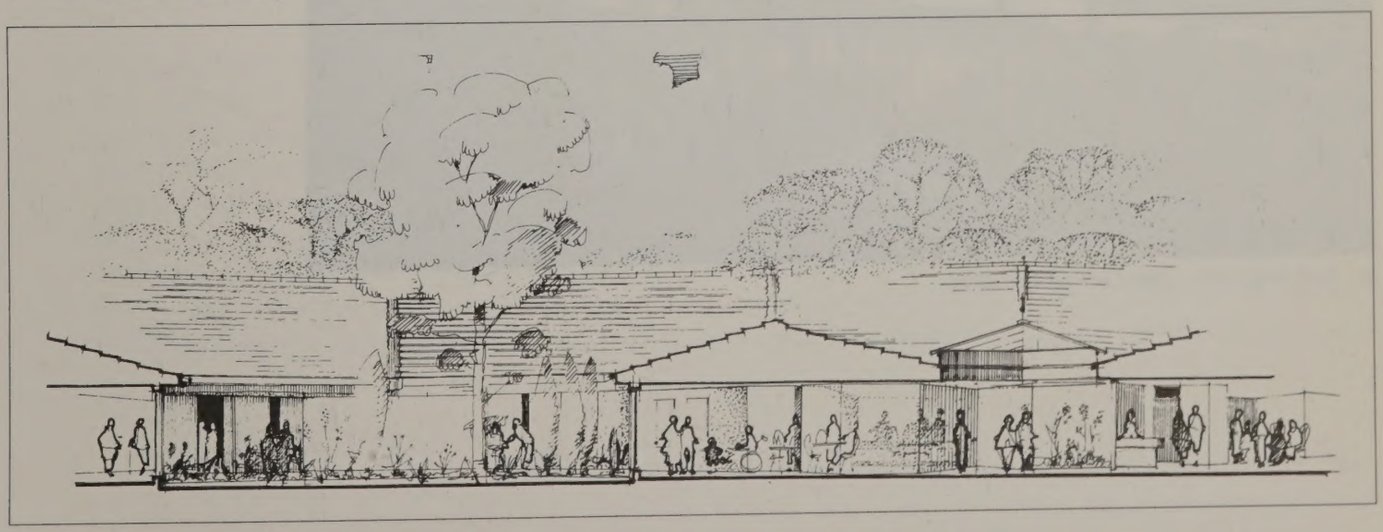
HBN 10 – 'Catering department' and HBN 11 – 'Central food production unit and satellite accommodation' (in preparation) will be relevant concerning operational aspects, but will not be relevant concerning the sizing of community hospital facilities.

9.9.4 Operational policies

The following operational policy issues require careful consideration:

- types of meals service. Cook-chill provision will have different implications for space and planning relationships both in the kitchen and in ward and day hospital areas, than a traditional kitchen producing bulk or plated meals.
- staffing levels and design may also be affected, where it is planned to rely to a significant degree on ready-made (conventional or frozen) meals. Equally this policy may be desirable where trained staff are difficult to recruit.
- smoking policy in the staff dining area. The needs of non smokers should be safeguarded.
- kitchens come in discrete sizes which may not provide an exact match to a hospital's requirements. Consideration should be given to marketing any spare capacity to other agencies (e.g. local authority day centres, schools, etc).
- staff dining areas can be made available for use by local residents, on an income generation basis.

64. View across the staff dining area



9.9.5 Planning issues and options

The following issues should be taken into account in the design of the kitchens:

- the flow of work and relationship of spaces and equipment in the main kitchen should take full account of hygiene regulation requirements.
- the scope for achieving a more domestic scale of operations should also be explored.

9.9.6 Relationship to other services

The catering department should be located:

- on the ground floor, where possible.
- with easy access from the kitchen to day hospital and ward areas
- with exterior access for supply and disposal.
- with direct access, where possible, from the staff dining area to courtyards or the hospital grounds.

9.9.7 Total quality management and interior design

The kitchen should provide:

- a comfortable and safe work environment for staff with adequate space, lighting and mechanical ventilation. The introduction of more stringent hygiene regulations, the removal of Crown Immunity, and the increased risk of infection due to poor hygiene practices, make these factors ever more important.

The staff dining area should provide:

- a comfortable environment for staff to get together away from their working areas. If there are no staff restrooms, this may be the only place where staff can meet.

9.9.8 Multi-use of space

It may also be possible to use the staff dining room for meetings and seminars.

65. Staff dining room – Blyth Community Hospital

9.10 Administration, health records and office accommodation

9.10.1 Scope

Accommodation may be required for each of the following:

- reception
- admissions and health records
- hospital and locality manager
- senior nursing staff
- meetings space, for use by managers, GPs and other professionals, voluntary groups
- teaching and seminar space, for use by all types of staff
- office base, for primary health care team staff (district nurses, health visitors, etc)
- chapel and quiet room, for use by relatives and visitors

Primary health care team staff will generally be based in health centres, clinics or GP surgeries, but a community hospital can provide an appropriate alternative location, particularly if GPs are also based on site, or close by.

9.10.2 Other relevant guidance

Health Building Note 47 – 'Health records department' provides guidance of general background interest, but it is aimed at the much larger health records department of a district general hospital.

Health Building Note 46 – 'General medical practice premises' whilst focusing on GP accommodation, also deals with the accommodation needs of primary health care team staff attached to GP practices. This guidance can, therefore, be used to determine office base requirements for these staff in a community hospital. Guidance is not provided in this document on these requirements.

9.10.3 Operational policies

The following operational policy issues require careful consideration:

- storage of x-ray films. Films will either be stored in the radiodiagnostic department or in the health records area.
- storage of minor casualty, rehabilitation, day hospital records. As for radiodiagnostics.

9.10.4 Planning issues and options

The following are issues to be taken into account in planning space for these functions:

- use of main reception as reception for minor casualty, out-patients or day hospital.
- shared use of meetings space(s) for teaching activities.
- appropriate provision of office accommodation for primary health care staff, which takes account of the likely peaked pattern of usage (e.g. busy early am, late pm, etc) and need for secure storage for papers, records, etc).

9.10.5 Multi-use of space

Multi-use of the staff dining area for meetings or teaching activities may be a possibility.

9.11 Linen and sewing room and patient clothing service

9.11.1 Scope

A patients clothing system is likely to be in use in the hospital for elderly patients. Local facilities will be needed for making, repairing and laundering patients' own clothing and clothing issued to them by the hospital. Facilities may also be needed for storage, measuring and fitting, and repair of staff uniforms, although this service might not be staffed full time. Laundry may be delivered directly to the wards and departments, where small stocks may be held. Alternatively, a central linen store will be needed.

9.11.2 Size

For a hospital of 60–100 beds, a patient clothing launderette might comprise three 22lb industrial type washing machines and two large tumble dryers, with ancillary space for sorting, marking and storage.

On the wards, a separate patient clothing store, including space for a mobile dress rail, will be appropriate for elderly and EMI wards. Bed spaces for the EMI and longer-stay elderly patients will need to accommodate a larger than usual bedside storage unit with hanging space for clothes. These bed spaces will also need to be used for assisted dressing.

9.11.3 Operational policies

The following operational policy issues require careful consideration:

- it may be appropriate for the launderette to be used for other purposes, such as washing of domestic mop heads.
- foul wash may be done at the laundry, rather than in the community hospital.

9.12 Supplies and stores

9.12.1 Scope

Community hospitals will generally receive the majority of their supplies from an off-site supplies and distribution centre.

A receipt and distribution area will generally be required in a community hospital. Whether or not a hospital store is also provided will be a matter for local decision. If no hospital store is provided, additional storage space will be required at departmental level (particularly on wards), to cope with bulky disposables and storage of other items which have to be ordered in bulk.

9.12.2 Other relevant guidance

Forthcoming Health Building Note 49 – 'Hospital receipt and distribution centre' provides relevant background guidance but it focuses on the accommodation requirements of a district general hospital.

9.13 Domestic services

A base will be required for the domestic services manager, together with central storage space for supplies and cleaning appliances to serve the whole hospital.

9.14 Staff changing

Where centralised staff changing facilities are required, they should be planned in accordance with Health Building Note 41 – 'Accommodation for staff changing and storage of uniforms'. Care should be taken to ensure that adequate provision is made for part time staff.

9.15 Mortuary

9.15.1 Scope

A mortuary (but not post-mortem facilities) with an appropriate number of body storage places and viewing facilities will be required.

9.15.2 Other relevant guidance

Health Building Note 20 – 'Mortuary and post-mortem room' is of general relevance to the planning of these facilities. The total number of body storage places required will generally be less than the minimum (six places) suggested in HBN 20.

9.16 Engineering services, estate maintenance and communications

9.16.1 Scope

Accommodation will be required for:

- boiler plant, and associated fuel storage where appropriate.
- electrical intake switchroom.
- emergency electrical generator, and associated fuel tank.
- local maintenance workshop facilities, and associated stores.
- cold water storage tanks.
- plant rooms for centralised ventilation, and possible refrigeration, plants.

Accommodation may be required for:

- centralised medical gases systems.

Appropriate provision of the following communications services will also be required:

- telephones
- hospital radio and TV
- staff location

9.16.2 Sizing

- **Boiler plant:** The boiler house will usually accommodate the boiler plant and hot water storage calorifiers together with associated water treatment plant, pumps and controls. Its size will vary to suit the heating and hot water demands of each specific project. Space for solid or liquid fuel storage, as appropriate, will be required. If gas is chosen as the primary fuel supply, a project decision will be required as to whether standby liquid fuel storage should also be provided.

- **Electrical supplies:** The intake switchroom will be the primary electricity distribution centre for the site. Its equipment and size will be specific for each project. In some instances the supply authority may require that electrical power be received at high voltage and additional accommodation will be needed for transformer(s) and associated high voltage and low voltage switchgear. The primary electrical distribution system will serve local switchrooms or cupboards which should be included as part of the functional content, as described in the relevant departmental HBNs.

- **Emergency generator:** The standby emergency generator will require its own accommodation in a location convenient for economic cable connections to the site's primary electrical distribution system, but away from the in-patient accommodation, to minimise disturbance from noise. For the range of electrical demands associated with community hospitals it will usually be more economic to install a standby generator capable of supplying the whole site, rather than provide separate essential and non-essential electrical distribution systems and a smaller size of generator.

- **Maintenance workshops and stores:** The detailed guidance concerning building and engineering trades maintenance and associated stores included in Health Building Note 34 – 'Accommodation for estate maintenance and works operations' is based on the accommodation requirements for a DGH site and will only be partly relevant to a community hospital site, depending on the level of support provided by offsite workshops. Consequently comprehensive engineering and woodworking machine shops are unlikely to be required, but a workshop with benches and a limited range of bench mounted power tools will be required for a variety of trades together with adjacent secure storage for essential spares and consumable materials.

  For the servicing of the electronic and medical engineering (EME) equipment at a community hospital site, the guidance given in HBN 34 for a satellite EME workshop is relevant.

- **Cold water storage:** Accommodation at high level will be required for cold water storage tanks. The supporting structure will need to be suitable for the weight of the water to be stored and safe access for maintenance personnel should be ensured. The amount of cold water storage will be specific for the demands of each project and may also have to satisfy conditions imposed by the relevant Water Supply Authority.

- **Plant rooms:** Accommodation will be required for centralised and local ventilation (and possibly air cooling/conditioning) plants. These will usually be sited near to the functions having the largest mechanical ventilation requirements, e.g. radiodiagnostic, kitchen (and, if provided, operating theatre and hydrotherapy pool). The size, number and location of plant rooms will be specific for each project.

- **Medical gases:** It will be a project decision as to whether the functional need for medical gases and medical vacuum is best served by portable apparatus or by a permanent distribution system connected to centralised medical gases storage and centralised medical air compressors and vacuum plant. If a centralised system is selected, secure external storage accommodation, with vehicular access, will be required for medical gas cylinders and associated manifolds. Central medical air compressors and medical vacuum plant may be accommodated in one of the plant rooms. Guidance on medical gases installations and terminal outlets is given in HTM 22 – 'Piped Medical Gases, Medical Compressed Air and Medical Vacuum Installations', and any subsequent published amendments.

- **Telephones:** The space requirements for telephone exchange apparatus and operators given in Health Building Note 48 – 'Telephone services', are those associated with a DGH site and will not be relevant for the smaller telephone system required in a community hospital. An operating console in the main reception area and an associated equipment cabinet will usually be sufficient unless the service is provided entirely as a satellite system coupled to a DGH or any other main site, as discussed in HBN 48.

- **Hospital radio and TV:** It will be appropriate to provide centralised radio and TV receiving apparatus to distribute sound and vision signals to the wards and other parts of the hospital. The equipment will usually be contained in a vertical equipment rack which will require secure accommodation with access for maintenance. An enlargement of one of the electrical distribution switchrooms may be appropriate provision. A suitable site will be required for the radio and TV receiving aerials.

- **Staff location:** It may be appropriate to provide a staff paging system similar to that at a DGH site. Guidance on these systems is given in Health Technical Memorandum 20 – 'Staff location systems' and their possible integration with the site telephone system is described in Health Building Note 48 – 'Telephone services'.

9.16.3 Operational policies

The following operational policy issue requires careful consideration:

- maintenance of the buildings, engineering services and medical equipment at a community hospital site will involve the same range of maintenance trades as a DGH site. However, the amount of activity will be less, due to the smaller scale of provision, with the consequence that permanent on-site presence of all maintenance trades is unlikely to be justifiable. The manner in which maintenance is organised and delivered at a particular site will be determined by health authorities in accordance with their estate management operational policies. The possible policy options and the factors involved are described and discussed in Health Building Note 34 – 'Accommodation for estate maintenance and works operations (in preparation).

9.16.4 Planning issues and options

The following issue should be taken in account in the provision of the telephone service:

- the planning and provision of the telephone installation at a community hospital should never be carried out in isolation. A review of the overall strategy for telephone services within the District is a prerequisite. Guidance on the factors to be taken into account is given in Health Building Note 48 – 'Telephone services'. This HBN also gives guidance on the telephone facilities that can be provided by a modern telephone system with an electronic exchange.

9.16.5 Other relevant guidance

- detailed guidance for engineering designers concerning the engineering service in the functional accommodation described in this Design Guide and their integration into systems suitable for a community hospital development is contained in the Engineering Services chapters of the HBN's listed in the bibliography. The engineering design criteria, materials specifications and reference data given in HBN guidance are also relevant to the functional requirements of a community hospital.

Notes

10 Cost and area guidance

Because this document is published as a "Design Guide" rather than a "Health Building Note" there will be no accompanying Departmental Cost Allowances (DCA's).

Community hospitals are generally smaller in scale than District General Hospitals but still involve substantial sums of money. To enable planners to assess the capital implications of these projects, cost guides for 50 bed and 90 bed exemplar community hospitals are set out in Table 66. From a survey of community hospitals it was found that the majority fell within the 50 to 90 bed range and by presenting the costs of budget format, it should enable users to interpolate and extrapolate to suit their own particular functional requirements.

The cost guides have been prepared in a similar manner to DCA's (but they do not have the same status) and represent the standards that can be found in the community hospitals described in this document.

Communications have been assessed from the schematic layouts but notional sums have been included for the balance of on-costs, such as drainage and external works, in order to indicate the total cost.

The cost guides are based on the areas shown in Table 66 and supported by the schedules of accommodation in Appendix 4. The schedules of accommodation are similar to those found in Health Building Notes and are published as background information and to assist at the early design stage. The schedules **do not** represent recommended room sizes neither will they necessarily translate into the project's final plan form.

Costs are inclusive of preliminaries but a 5% design reserve and a 2% contingency have been shown separately. Nothing has been included for equipment or professional fees. A survey of three recently completed community hospitals in the 30–50 bed range show equipment costs to be averaging about 21% of the total departmental costs.

The cost guides have assumed a fairly level site with normal soil conditions. The merits of individual sites should be taken into account at project level and in particular those conditions which affect substructure and external works.

Where the accommodation is biased towards the elderly an allowance should be made for additional ventilation. For the 50 bed exemplar this allowance should be £53,000 and for the 90 bed exemplar £94,000.

No allowance has been made for on-site incineration as this facility is not usually required at community hospitals.

On-costs include £35,000 for a building energy management system. This sum includes for a remote control outstation which is likely to be the preferred option for community hospitals.

The cost guides in Table 66 are at MIPS VOP 264 which corresponds with the DCA index at the time of publication of this document. When using the cost guides it will be necessary to make adjustments for the index required and in particular for the "firm price" adjustment that is most likely to apply to community hospitals. The corresponding MIPS Firm Price Index is 277.

Department	Example 1 50 beds 20 day places			Example 2 90 beds 40 day places		
	Funct'l content	Area sq.m	Dept cost £'000	Funct'l content	Area sq.m	Dept cost £'000
In-patients						
20 bed ward	2 wards	1,323	802	3 wards	1,985	1,202
10 bed ward	1 ward	365	231	3 wards	1,094	693
shared facilities		67	44		67	44
Rehabilitation						
20 place day/hos	1	189	111	2	378	223
physiotherapy		197	110		231	131
OT		152	94		183	114
speech therapy		28	14		28	14
shared facilities		152	97		159	101
Treatment and O/P						
central treatment	1	33	25	1	33	25
C/E suites	4	101	59	6	145	84
casualty	1	33	26	1	33	26
dental suite				1	63	45
endoscopy				1	108	76
shared facilities		129	87		161	108
Radiology						
RD rooms	1 room	160	124	1 room	197	154
Main entrance						
main entrance		153	101		176	116
administration, reception, records		178	98		215	118
Ancillary/Support						
kitchen	99 meals	110	134	183 meals	140	170
dining	25 places	45	29	45 places	80	51
mortuary	3 places	47	53	6 places	52	62
linen		66	39		66	39
domestic		21	10		21	10
supplies		78	44		118	66
staff change		100	55		100	55
telephones	32 extensions	5	17	58 extensions	5	29
boiler house	1000kW's	50	170	1600kW's	65	228
works		70	30		80	33
Departmental total		3,852	2,604		5,983	4,017
On-costs						
communications		630	275		1,155	499
int/ext engineering			289			363
Sub-total		4,482	3,168		7,138	4,879
External works/services			391			603
Sub-total			3,559			5,482
Design Reserve 5%			178			274
Sub-total			3,737			5,756
Contingencies 2%			75			115
Total			3,812			5,871

66. Community hospitals cost guides @MIPS VOP 264

Appendix 1 – Historical background

Cottage hospital origins. The first cottage hospital was established in 1858 by Dr Albert Napper. It was literally a cottage with an optimum number of 6 beds "identical to the homes from which patients were drawn, differing only in warmth, proper hygiene and absence of overcrowding" (Loudon 1973).

Cottage hospitals were originally intended to serve rural areas with poor transport facilities.

By 1934 there were over 600 cottage hospitals (a total of 10,000 beds) with anything from 6–40 beds. They were incorporated into the NHS in 1948 but often provided services in an isolated manner unrelated to mainstream health care. (While 1978)

1962. DHSS-Hospital Plan for England and Wales recommended concentration of hospital care into DGHs and created uncertainty about future of cottage hospitals.

Late 60s. Oxford RHB, in response to difficulty of providing DGH services to rural areas, developed concept of community hospital, defined as follows:

> "The ideal model of a community hospital is seen to comprise a health centre with accommodation for GPs, their staff, LA services, consultant clinics and certain diagnostic services; day treatment facilities and in-patient accommodation. Thus a full range of integrated facilities is provided at community level to serve the needs of a defined population."
>
> "Patients suitable for admission to a community hospital may be broadly described as patients who, while requiring hospital care as they cannot be managed at home, do not require the facilities of a DGH nor the services of a specialist team." (Rue 1972)

Experimental units were set up in Oxford RHB at Peppard and Wallingford hospitals. Community hospitals in Oxford RHB were seen as an extension of primary care not as a peripheralization of acute hospital services.

1969. Bonham Carter Report (DHSS Welsh Office) implied closure of small hospitals in describing the role of DGHs.

1969. Association of GP community hospitals established to encouraged further development of community hospitals and maintenance of standards of care.

1972. Community hospital concept endorsed jointly by RCP and RCGP. Concerns expressed about maintenance of clinical standards.

1974. DHSS guidance on community hospitals (DHSS Welsh Office) recognised difficulty in providing health care to rural areas. Saw community hospitals as having 50–150 beds (seldom lower than 50 beds). Acknowledged the need for variations in size and content to meet local needs and for community hospital planning to be fully integrated into regional plans and coordinated with social services. Community hospitals were seen as:

> "providing medical and nursing care, including out-patient, day patient and in-patient care for people who do not need the specialized facilities of the DGH and cannot be properly cared for at home in residential accommodation. Some patients will be admitted direct to and discharged from them. For other patients, the community hospital will be a bridge (in either direction) between the DGH and primary care."

The circular suggested community hospitals could provide for:

- up to 1/2 the geriatric in-patient beds and day places in a health district
- in-patient and day places for elderly patients with dementia
- some out-patient clinics
- terminally ill patients and those with chronic disabilities
- medical and surgical patients no longer requiring DGH facilities

GPs seen as having day-to-day responsibility for patients. Consultants to run OPD clinics. Scope for GPs and consultants to work together.

Health centres and GP practice premises seen as closely associated with a community hospital.

DHSS view was similar to Oxford RHB but with addition of services for elderly patients and those patients with dementia.

Envisaged some new purpose built community hospitals plus conversion of some existing cottage hospitals.

Circular implied closure of smaller hospitals with less than 50 beds.

1977. DHSS The Way Forward suggested a more flexible approach to provision of community hospitals.

1978. Study by Cavenagh (Cavenagh 1978) set out for the first time the range and scope of work being done in general practitioner hospitals. Study identified a total of 350 general practitioner hospitals.

1979. RCGP-General Practitioner hospitals (RCGP Paper 23 published in 1983) – expressed concern about threat posed by 1974 DHSS guidance to small GP hospitals:

- lack of support for surgical services other than minor surgical and minor casualty services
- and focus of DGH for maternity services.

Main criticism of 1972 circular was concern about the appropriateness of a uniform plan for community hospitals. RCGP endorsed the argument for 'local planning sensitive to local needs'.

1980. DHSS Consultation Paper-Future Pattern of Hospital Services. Change in economic climate and adverse public reaction to closure of small hospitals. Need for peripheral hospitals acknowledged by DHSS. "Blueprint" idea withdrawn, health authorities encouraged to determine own peripheral hospital requirements within the context of national and regional policies.

1985. RCS-Commission on provision of surgical services for small communities; the role of the GP hospital expressed continued support for 'surgical services in community hospitals for carefully selected patients'.

Surgical services seen to include:

- consultant OPD clinics
- post-op surgical care
- in-patient or day patient procedures undertaken by GP or consultant.

Stressed need to define type of surgery appropriate for GP hospitals. Sets out minimal requirement for staffing and accommodation. Notes a general decline in surgical activity as a total number of GP hospitals has declined.

1989/90. White Paper – Working for patients. Introduction of purchaser/provider roles, NHS trusts; internal markets, capital charges; These changes may create an even greater variety of community hospital provision.

Appendix 2 – Recently completed community hospitals

				Bed complement						Other facilities				
Hospital	Region	District	Date built (not purpose built)	Total beds	GP acute beds	Cons. acute beds	Cons. elderly beds	EMI/ ESMI beds	Other beds	Casualty	Operating theatre	X-Ray	Outpatient clinics	GP premises on site
Ilkeston	T	S Derbys	1987	92	24		48	20		×	×	×	×	
Caithness	Scot	Highlands	1986	121	×	58	48		15 mat'y	A&E	×	×	×	
Bridlington	Y	E Yorks	1988	206	16	72	72	18	12 MI 16 mat'y	×	×	×	×	
Seaton	SW	Exeter	1988	24	15			9					×	
Blandford	W	W Dorset	1986	66	22		24	80		×	×	×	×	
Blyth	N	N'land	1987	78	26		38	14		×		×	×	×
Bromyard	WM	Hereford	1989	20	5		15						×	
Bolsover	T	N Derbys	1988	72	12		36	24					×	
Jarrow	N	S Tyneside	1986	82	10		46	26		×		×	×	×
South Molton	SW	N Devon	1987	28	11		17			×				
Coalville	T	Leics	1988	96	24		48	24				×	×	
Millom	N	Cumbria	NK*	14	10		4						×	
Cockermouth	N	Cumbria	NK*	17	10		3			×			×	
Goole	Y	Scunthorpe	1988	154	6	54	60	24	10 mat'y	×	×	×	×	
Stratford	WM	S Warks	1988	119	40	24	55			×	×		×	×
Clacton	NET	NE Essex	1984	115 }	55		60							
			1988	60 }			60	×						
Skegness	T	S Lincs	NK*	26 +	26	×				×	×		×	
Ystradgynlais	Wales	Powys	1985	52	14		30	8				×	×	
Mold	Wales	Clwyd	1984	40	20		20			×		×	×	
Andover	W	Winchester	1987	110	28		44	28	10 mat'y	×		×	×	×

Source: 1989, Regional telephone survey

Appendix 3 – Sizing methods

3.1 Physiotherapy

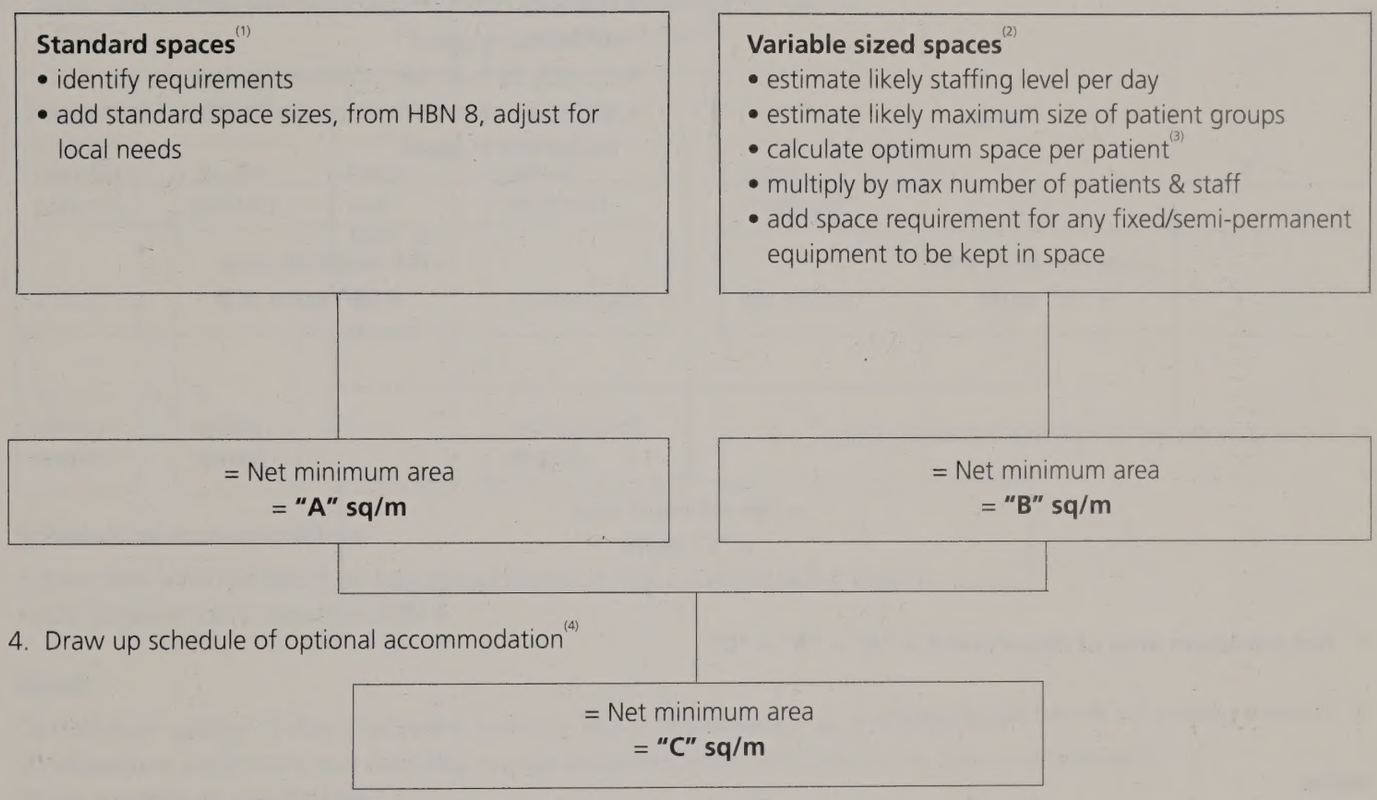
Workload calculation

1. Determine nature of service to be provided

2. Estimate likely workload:
   - refer to existing DGH inpatient, outpatient and day patient workload from community hospital catchment area
   - deduct workload likely to remain with DGH
   - adjust remainder for likely OPD service at community hospital
   - adjust for known changes to pattern of contracts with purchasing authorities.

Schedule of accommodation

3. Draw up schedule of essential accommodation:



4. Draw up schedule of optional accommodation(4)

5. **Net minimum area of department = "A" + "B" + "C"**

6. Examine options for shared use of spaces with OT, Day Hospital

Notes.

(1) Office, changing, storage, etc
(2) Exercise area, etc
(3) Four sq/m per patient is suggested
(4) Ultraviolet room, hydrotherapy pool, etc

3.2 Occupational therapy

Workload calculation

1. Determine nature of service to be provided

2. Estimate likely workload:
   - refer to existing DGH inpatient, outpatient and day patient workload from community hospital catchment area
   - deduct workload likely to remain with DGH
   - adjust remainder for likely increased usage by GPs and LAs
   - adjust for known changes to pattern of contracts with purchasing authorities.

Schedule of accommodation

3. Draw up schedule of essential accommodation:

Standard spaces[1]
- identify requirements
- add standard space sizes for local needs

= Net minimum area
= **"A" sq/m**

Variable sized spaces[2]
- estimate likely staffing level per day
- estimate likely maximum size of patient groups
- estimate likely proportion of wheelchair patients
- calculate optimum space per wheelchair/non-wheelchair patient[3]
- multiply by max size of patient groups
- add space requirement for any fixed/semi-permanent equipment in space

= Net minimum area
= **"B" sq/m**

4. Draw up schedule of optional accommodation[4]

= Net minimum area
= **"C" sq/m**

5. **Net minimum area of department = "A" + "B" + "C"**

6. Examine options for shared use of spaces

Notes.
(1) ADL suite, interview, storage, office, etc
(2) General activity space, craft workshop, etc
(3) 3.25 sq/m per patient in wheelchair, etc
(4) Splint room, heavy workshop, etc

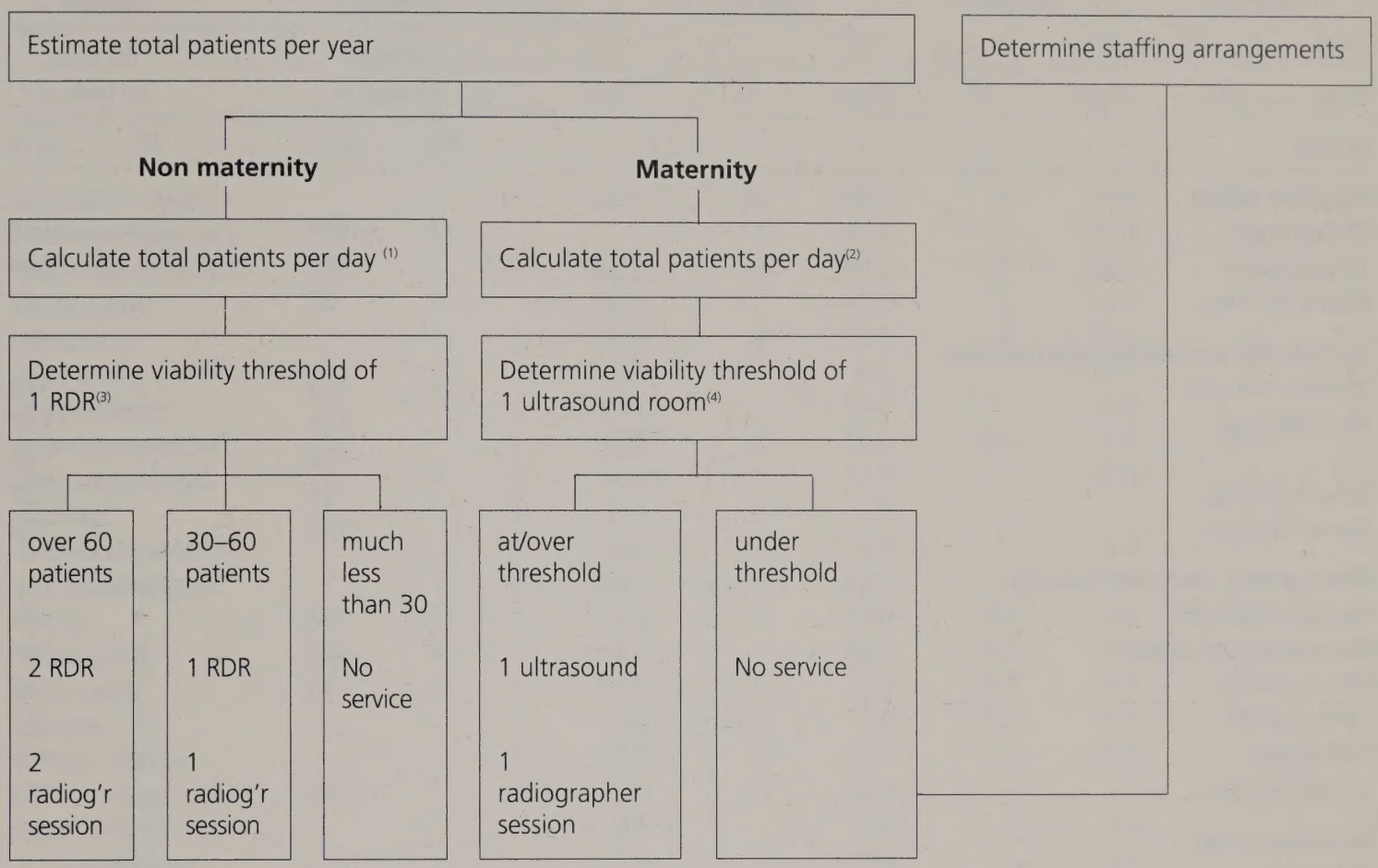
3.3 Radiodiagnostics

Workload calculation

- refer to existing DGH workload
- identify DGH workload referred from potential community hospital catchment area
- allow for known changes to pattern of contracts with purchasing authorities
- allow for likely increased usage by GPs of local facility

Staffing calculation

- Examine options for
  - Radiographer cover
  - Reporting by Radiologist



Schedule of accommodation

- determine schedule based on functional content ie 1 or 2 RDR, ultrasound room
- add standard room sizes from HBN 6

Notes

(1) Calculate number of days machine is available, net of maintenance, eg 235 days/year
(2) Ultrasound equipment may need less maintenance; workload will come mainly from antenatal clinic
(3) For example 30 patients/day
(4) May be less than 30 patients/day for ultrasound

Appendix 4 – Schedules of accommodation

4.1 Functional content and accommodation by service

Service	Example 1 50 beds 20 days pl		Example 2 90 beds 40 beds pl	
	FC	sq. m	FC	Sq.m
In-patient wards				
20 bed ward	2	1323	3	1985
10 bed ward	1	365	3	1094
shared facilities	1	67	1	67
Day hospital and rehabilitation services				
20 place DH core	1	189	2	378
Physiotherapy		197		231
OT		152		183
Speech therapy		28		28
Shared facilities		152		159
Clinic services and minor casualty				
Central treatment	1	33	1	33
Out-patient C/E suites	4	101	6	145
Minor casualty	1	33	1	33
Central suite			1	63
Endoscopy			1	108
Shared facilities		129		161
Radiodiagnostics				
X-ray (rdrs)	1	160	1	197
Main entrance and administration				
Main entrance		153		176
Admin		178		215
Reception				
Records				
Ancillary and support services				
Kitchen	99	110	183	140
Dining	25	45	45	80
Mortuary	3	47	6	52
Linen		66		66
Domestic		21		21
Supplies		78		118
Staff change		100		100
Telephones		5		5
Works/plant		170		205
Departmental total		3902		6041
Whole Hosp circulation (say 10%)		390		604
Total		**4292**		**6645**
Gross area/bed		85.8		73.8

4.2 Wards

Area	20 beds (1)		20 beds (2)		10 beds (1)		10 beds (2)	
	FC	sq.m	FC	sq.m	FC	sq.m	FC	sq.m
Bedroom – single	4	48.0	10	120.0	4	480	8	96.0
Multi-bed room × 2			1	24.0	1	24.0	1	24.0
Multi-bed room × 4	4	160.0	2	80.0	1	40.0		
Quiet room		12.0		12.0		12.0		12.0
Day/dining	3	75.0	3	75.0	2	31.5	2	31.5
Staff base		6.5		6.5		6.5		6.5
Physiotherapy		13.0		13.0		6.5		6.5
Bath/treatment/WC	1	15.0	1	15.0	0.5	7.5	0.5	7.5
Bath assisted/WC	1	14.0	1	14.0	1	14.0	1	14.0
Bath/WC	1	7.0	1	7.0				
Shower assisted/WC	1	6.0	1	6.0	1	6.0	1	6.0
WC assisted/wash	4	22.0	4	22.0	2	11.0	2	11.0
Pantry	1	12.0	1	12.0	0.5	6.0	0.5	6.0
Clean utility	1	10.0	1	10.0	0.5	5.0	0.5	5.0
Dirty utility	1	10.0	1	10.0	0.5	5.0	0.5	5.0
Cleaner	1	3.0	1	3.0	0.5	1.5	0.5	1.5
Office – doctor	1	12.0	1	12.0	1	12.0	1	12.0
– ward	1	12.0	1	12.0				
Staff – WCs		3.0		3.0		3.0		3.0
– lockers		2.5		2.5		2.5		2.5
Store – linen		6.0		6.0		3.0		3.0
– patients clothing		4.0		4.0		2.0		2.0
– equipment		10.0		10.0		5.0		5.0
– wheelchair bay		6.0		6.0		5.0		6.0
Disposal		2.0		2.0		2.0		2.0
Switch		3.0		3.0		2.0		2.0
Nett total		474.0		490.0		261.0		270.0
Circulation, etc	35%	165.9	35%	171.5	35%	91.4	35%	94.5
Totals		**639.9**		**661.5**		**352.4**		**364.5**
Space/bed gross		32.0		33.1		35.2		36.5
nett		10.4		11.2		11.2		12.0
Shared accommodation								
ADL suite – kitchen/dining		15.0						
– bathroom		9.6						
– bedroom		10.8						
Relatives room		14.0						
Nett total		49.4						
Circulation etc	35%	17.3						
Total		**66.7**						

4.3 Rehabilitation

Area	Example 1		Example 2		Comments
	FC	sq.m	FC	sq.m	
Physiotherapy					
Treatment – cubicles	3	30.0	4	40.0	
– exercise area	10	48.0	12	56.0	
Interview/treatment	1	12.0	1	12.0	
Staff workstations		4.0		4.0	
Patient changing		8.0		10.0	
Office	1	12.0	1	12.0	
Storage		12.0		17.0	
Wax room	1	10.0	1	10.0	
Ultraviolet room	1	10.0	1	10.0	
Nett total		146.0		171.0	
Circulation	35%	51.1	35%	59.9	
Totals		**197.1**		**230.9**	
Occupational therapy					
ADL suite – kitchen/dining		15.0		15.0	
– bathroom		9.6		9.6	
– bedroom		10.8		10.8	
Activity area	14	47.5	20	67.0	
Interview/treatment					see day hospital
Store		8.0		11.5	
Office	1	12.0	1	12.0	see day hospital
Workshop		10.0		10.0	
Nett total		112.9		135.9	
Circulation etc	35%	39.5	35%	47.6	
Total		**152.4**		**183.5**	
Speech therapy					
Speech therapy	1	15.5	1	15.5	
Store	1	15.0	1	15.0	
Nett total		20.5		20.5	
Circulation etc	35%	7.2	35%	7.2	
Total		**27.7**		**27.7**	

4.3 Rehabilitation (cont)

Area	Example 1		Example 2		Comments
	FC	sq.m	FC	sq.m	
Shared accommodation					
Reception	1	6.0	1	6.0	see also main entrance
Waiting	5	8.5	8	13.6	see also main entrance
Interview/treatment					see day hospital
WC assisted	1	5.5	1	5.5	
Chiropody	1	14.0	1	14.0	
Hairdressing	1	11.0	1	11.0	
Bath/treatment/WC	1	15.0	1	15.0	
Clean utility	1	10.0	1	10.0	
Dirty utility	1	10.0	1	10.0	
Pantry	1	12.0	1	12.0	
Staff facilities – rest	1	12.0	1	12.0	
– WC		3.0		3.0	
– lockers		2.5		2.5	
Disposal		2.0		2.0	
Switch		1.0		1.0	
Nett total		112.5		117.6	
Circulation etc	35%	39.4	35%	41.2	
Total		**151.9**		**158.8**	
Day hospital core					
Forum		28.0			
Quiet room		12.0			
Dining/sitting	2	48.0			
C/E room/interview	1	12.0			
Assisted bathroom/WC	1	14.0			
WCs assisted	4	22.0			
OT Office					see OT
Patients cloaks		4.5			
Store – linen		3.0			
– general		6.0			
Wheelchair bay		6.0			
Switch		2.0			
Nett total		157.5		315.0	
Circulation etc	20%	31.5	20%	63.0	
Total		**189.0**		**378.0**	

4.4 Clinic services

Area	Example 1		Example 2		Comments
	FC	sq.m	FC	sq.m	
Out-patients					
Reception/control point		6.0		6.0	see also main entrance
Records					see main entrance
Sub-wait	3	5.1	3	5.1	see also main entrance
Consult/exam	4	64.0	6	96.0	
Nett total		75.1		107.1	
Circulation etc	35%	26.3	35%	37.5	
Total		**101.4**		**144.6**	
Dental suite					
Reception/office			1	8.0	
Sub-wait			5	8.5	
Treatment			1	16.0	
Recovery			1	6.0	
Lab/workroom				6.0	
Store				2.0	
Nett total				46.5	
Circulation etc	35%		35%	16.3	
Total				**62.8**	
Treatment					
Sub-wait	5	8.5	5	8.5	
Treatment	1	16.0	1	16.0	
Utility					see shared facilities below
Nett total		24.5		24.5	
Circulation etc	35%	8.6	35%	8.6	
Total		**33.1**		**33.1**	
Minor casualty					
Sub-wait	5	8.5	5	8.5	
Treatment	1	16.0	1	16.0	
Utility					see shared facilities below
Nett total		24.5		24.5	
Circulation etc	35%	8.6	35%	8.6	
Total		**33.1**		**33.1**	

4.4 Clinic services (cont)

Area	Example 1		Example 2		Comments
	FC	sq.m	FC	sq.m	
Endoscopy					
Reception/office			1	8.0	
Sub-wait			5	8.5	
Patient WC			1	5.5	
Patient changing				8.0	
Treatment			1	20.0	
Recovery			1	12.0	
Clean utility			1	10.0	
Dirty utility					see shared facilities below
Lab/workroom				6.0	
Store				2.0	
Nett total				80.0	
Circulation etc	35%		35%	28.0	
Total				**108.0**	
Shared facilities					
Waiting	15	25.5	20	34.0	might be integrated with ME
Clean utility	1	10.0	1	10.0	
Dirty utility	1	10.0	1	10.0	
Patients WCs	1	5.5	2	11.0	see also main entrance
Equipment store	2	10.0	2	10.0	
Wheelchair/trolleys	1	5.0	2	10.0	
Office	1	12.0	1	12.0	
Staff facilities WC	1	3.0	1	3.0	
lockers	1	2.5	1	2.5	
Linen store	1	4.0	2	8.0	
Disposal	1	2.0	1	2.0	
Weighing room	1	4.0	1	4.0	
Switch	2	2.0	3	3.0	
Nett total		95.5		119.5	
Circulation etc	35%	33.4	35%	41.8	
Total		**128.9**		**161.3**	

4.5 Radiodiagnostics

Area	Example 1		Example 2		Comments
	FC	sq.m	FC	sq.m	
Reception		6.0		6.0	
Sub-wait	6	10.2	8	13.6	
Patient WC – WC	1	5.5	1	5.5	
– changing		6.0		8.0	
– shower				6.0	
Ultrasound			1	16.0	
X-ray room	1	30.0	1	30.0	
Processing area		15.0		15.0	
Viewing area					
Dark room		5.0		5.0	
Office	1	12.0	1	12.0	
Staff facilities – WCs	1	3.0	1	3.0	
– lockers	1	2.5	1	2.5	
Store – film		5.0		5.0	
– chemical					
– linen		3.0		3.0	
– filing		15.0		15.0	
Nett total		118.2		145.6	
Circulation etc	35%	41.4	35%	51.0	
Total		**159.6**		**196.6**	

4.6 Main entrance

Area	Example 1		Example 2		Comments
	FC	sq.m	FC	sq.m	
Main entrance					
Reception	3	18.0	4	24.0	
Waiting – main	15	25.5	20	34.0	
– play		5.0		7.5	
Wheelchair		5.0		5.0	
Pram		5.0		5.0	
WC	2	11.0	2	11.0	
Mother/baby	1	4.0	1	4.0	
Tea bar/Vending		8.0		8.0	
Shop		16.0		16.0	
Porters		16.0		16.0	
Pharmacy (dispensary)					
Nett total		113.5		130.5	
Circulation	35%	39.7	35%	45.7	
Total		**153.2**		**176.2**	
Administration					
Admin (whole hospital)	8	60.0	14	72.0	
Health records	10K	30.0	15K	45.0	
Seminar		24.0		24.0	
Staff facilities – rest		12.0		12.0	
– WC	2	6.0	2	6.0	
Nett total		132.0		159.0	
Circulation etc	35%	46.2	35%	55.7	
Total		**178.2**		**214.7**	

4.7 Ancillary services

Area	Example 1		Example 2		Comments
	FC	sq.m	FC	sq.m	
Mortuary					
Body store	3	210	6	26.0	
Viewing		26.0		26.0	
Total		47.0		52.0	
Linen					
Uniform/linen store		26.0		26.0	
Patient clothing laundrette		25.0		25.0	
Sewing		15.0		15.0	
Total		66.0		66.0	
Domestic					
Office		11.0		11.0	
Rest					
Change					
Central equipment/materials store		10.0		10.0	
Departmental cleaners					
Total		21.0		21.0	
Telephones		5.0		5.0	
Stores					
Receiving/holding/loading		50.0		60.0	
Portering					
Equipment/bed store		20.0		40.0	
Office				10.0	
Trolley park		8.0		8.0	
Total		78.0		118.0	
Staff change (central)		100.0		100.0	
Works					
Boiler house		50.0		65.0	
Maintenance/workshops/st		70.0		80.0	
Plant		50.0		60.0	
Total		170.0		205.0	
Total gross area		**487.0**		**567.0**	

Appendix 5 – Other relevant Health Building Notes

1 Buildings for the Health Service, 1988. HMSO
2 The Whole Hospital, (in preparation).
3 The Design of the Hospital. Development control planning, (in preparation).
4 Adult Acute Ward, 1990. HMSO.
6 Radiodiagnostic department, 1985. HMSO.
8 Rehabilitation – accommodation for physiotherapy, occupational therapy and speech therapy, 1991. HMSO.
10 Catering Department, 1986. HMSO.
11 Catering – Central Processing Unit and satellite accommodation (in preparation).
12 Out-patients's department, 1989, HMSO.
20 Mortuary and post-mortem (in preparation).
21 Maternity Department, 1989. HMSO.
26 Operating department, 1991. HMSO.
34 Accommodation for Estate Maintenance and Works Operations (in preparation).
35 Accommodation for people with Acute Mental Illness, 1988, HMSO.
37 Hospital accommodation for Elderly people, 1981. HMSO.
38 Accommodation for adult acute day patients, 1982. HMSO.
40 Common Activity Spaces
Vol 1 Example layouts; common components, 1986. HMSO.
Vol 2 Corridors, 1986. HMSO
Vol 3 Lifts and stairways, 1989. HMSO.
Vol 4 Designing for disabled people, 1989. HMSO.
41 Accommodation for staff changing and storage of uniforms, 1984. HMSO.
46 General Medical Practice Premises (in preparation).
47 Health records department, 1991. HMSO.
48 Telephone Services, 1989. HMSO.
49 Hospital receipt and distribution centre (in preparation).
51 Accommodation at the main entrance of a DGH (in preparation).
52 Day Unit (in preparation).

Bibliography

Community Hospitals – their role and development in the NHS, Department of Health. 1974.

Contribution of general practitioner hospitals in England and Wales, Cavenagh, A.J.M. British Medical Journal. 1 July 1978.

Blyth Community Hospital and Health Centre, Hospital Development Vol 9 No 6, Nov/Dec. 1981.

General Practitioner Hospitals, Royal College of General Practitioners. Occasional paper 23.

Guidelines for surgical services in general practitioner hospitals, Shaw, C.D. Privately printed. 1983.

Mold Community Hospital, Building. Vol 247 No 7368, Nov 9. 1984.

Surgical services for small communities – the role of the general practitioner hospital, Royal College of Surgeons of England. 1985.

Contribution of General Practitioner Hospitals Scotland, Grant, J.A. British Medical Journal Vol 288. 5th May 1984.

Community Hospital Planning, West Midlands Regional Health Authority. 1984.

Association of General Practitioner Community Hospitals. Handbook and Directory, 1985.

Close to their roots (article on Blandford Community Hospital), Sadler. C. Nursing Mirror Vol 160, No 8. 1985.

Lambeth Community Care Centre, Lubbock, J. with Buchannan, P. and Ashton, J. Architect's Journal. 16 October 1985.

Example of Intermediate Care: the new Lambeth Community Care Centre, Higgs, R. British Medical Journal Vol 291. 16 Nov 1985.

Community Hospital, Ash Grove, Mold, Clwyd, Brick Bulletin, No 4/85. 1985.

Small is beautiful in Whitby, Harris, C. British Medical Journal Vol 293. 12 July 1986.

Ystradgynlais Community Hospital, Building. London Vol 251 no 7455. July 25 1986.

Community Hospitals in Oxfordshire: their effect on the use of specialist inpatient services, Baker, J. Goldacre, M. Muir Gray, J. A. J Epidemilogy and Community Health, Vol 40. 1986.

The role and function of community hospitals, Tucker, H. Kings Fund Project Paper 70. 1987.

Towards good practices in Community Hospitals – some suggested guidelines, NAHA. 1988.

The Role of Community Hospitals, Jones, R. and Tucker, H. Health Trends Vol 20. 1988.

Community Hospitals: consultative document, South East Thames Regional Health Authority. March 1989.

A Hospital for the Future, Rawlinson, C. Kelly, J. Hospital Management International, International Hospital Federation. 1989.

Local Heroes, Rawlinson, C., Hospital Development. September 1990.

Community hospital, preparing for the future, Royal College of General Practitioners. Occasional Paper 43. 1990.

NHS Estates is a non-profit making executive agency of the Department of Health.

The price of this publication has been set to make some contribution to the costs incurred by NHS Estates in its preparation.

Printed in the United Kingdom for HMSO
Dd 294391 c13 11/91

Department of Health

Welsh Office

Department of Health and
Social Services
Northern Ireland

HMSO publications are available from:

HMSO Publications Centre
(Mail and telephone orders only)
PO Box 276, London, SW8 5DT
Telephone orders 071-873 9090
General enquiries 071-873 0011
(Queuing system in operation for both numbers)

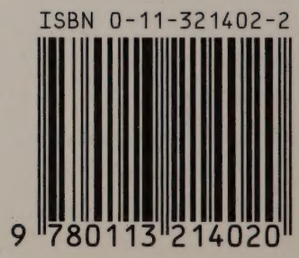
HMSO Bookshops
49 High Holborn, London, WC1V 6HB 071-873 0011 (counter service only)
258 Broad Street, Birmingham, B1 2HE 021-643 3740
Southey House, 33 Wine Street, Bristol, BS1 2BQ (0272) 264306
9-21 Princess Street, Manchester, M60 8AS 061-834 7201
80 Chichester Street, Belfast, BT1 4JY (0232) 238451
71 Lothian Road, Edinburgh, EH3 9AZ 031-228 4181

HMSO's Accredited Agents
(see Yellow Pages)

and through good booksellers

HMSO C

ISBN 0-11-321402-2



Design Guide

The design of community hospitals

NHS Estates

HMSO